113TH CONGRESS
1ST SESSION

H. R. 3165

To repeal the Patient Protection and Affordable Care Act and to take meaningful steps to lower health care costs and increase access to health insurance coverage without raising taxes, cutting Medicare benefits for seniors, adding to the national deficit, intervening in the doctor-patient relationship, or instituting a government takeover of health care.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 20, 2013

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

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A BILL

To repeal the Patient Protection and Affordable Care Act and to take meaningful steps to lower health care costs and increase access to health insurance coverage without raising taxes, cutting Medicare benefits for seniors, adding to the national deficit, intervening in the doctor-patient relationship, or instituting a government takeover of health care.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 "Common Sense Health Reform Americans Actually Want
4 Act".

5 (b) PURPOSE.—The purpose of this Act is to take
6 meaningful steps to lower health care costs and increase
7 access to health insurance coverage (especially for individ-
8 uals with preexisting conditions) without—

9 (1) raising taxes;

10 (2) cutting Medicare benefits for seniors;

11 (3) adding to the national deficit;

12 (4) intervening in the doctor-patient relation-
13 ship; or

14 (5) instituting a government takeover of health
15 care.

16 (c) TABLE OF CONTENTS.—The table of contents of
17 this Act is as follows:

Sec. 1. Short title; purpose; table of contents.
Sec. 2. Repeal of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

DIVISION A—ENSURING COVERAGE FOR INDIVIDUALS WITH PRE-EXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

Sec. 101. Establish universal access programs to improve high risk pools and reinsurance markets.
Sec. 102. No annual or lifetime spending caps.
Sec. 103. Preventing unjust cancellation of insurance coverage.

DIVISION B—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Subtitle A—Enhanced Marketplace Pools

Sec. 201. Rules governing enhanced marketplace pools.
Sec. 202. Cooperation between Federal and State authorities.
Sec. 203. Effective date and transitional and other rules.

Subtitle B—Market Relief

Sec. 204. Market relief.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS

Sec. 211. Extending coverage of dependents.
Sec. 212. Prohibiting preexisting condition exclusions for enrollees under age 19.
Sec. 213. Health plan finders.

TITLE III—EXPANDING CHOICES BY ALLOWING AMERICANS TO BUY HEALTH CARE COVERAGE ACROSS STATE LINES

Sec. 221. Interstate purchasing of health insurance.

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

Sec. 231. HSA funds for premiums for high deductible health plans.
Sec. 232. Requiring greater coordination between HDHP administrators and HSA account administrators so that enrollees can enroll in both at the same time.
Sec. 233. Special rule for certain medical expenses incurred before establishment of account.

TITLE V—TAX–RELATED HEALTH INCENTIVES

Sec. 241. SECA tax deduction for health insurance costs.
Sec. 242. Deduction for qualified health insurance costs of individuals.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

Sec. 301. Cap on non-economic damages against health care practitioners.
Sec. 302. Cap on non-economic damages against health care institutions.
Sec. 303. Cap, in wrongful death cases, on total damages against any single health care practitioner.
Sec. 304. Limitation of insurer liability when insurer rejects certain settlement offers.
Sec. 305. Mandatory jury instruction on cap on damages.
Sec. 306. Determination of negligence; mandatory jury instruction.
Sec. 307. Expert reports required to be served in civil actions.
Sec. 308. Expert opinions relating to physicians may be provided only by actively practicing physicians.
Sec. 309. Payment of future damages on periodic or accrual basis.
Sec. 310. Unanimous jury required for punitive or exemplary damages.
Sec. 311. Proportionate liability.
Sec. 312. Defense-initiated settlement process.
Sec. 313. Statute of limitations; statute of repose.
Sec. 314. Limitation on liability for Good Samaritans providing emergency health care.
Sec. 315. Definitions.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

Sec. 401. Rule of construction.
Sec. 402. Repeal of Federal Coordinating Council for Comparative Effectiveness Research.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

Sec. 501. Incentives for prevention and wellness programs.

DIVISION F—PROTECTING TAXPAYERS

Sec. 601. Permanently prohibiting taxpayer funded abortions and ensuring conscience protections.
Sec. 602. Improved enforcement of the Medicare and Medicaid secondary payer provisions.
Sec. 603. Strengthen Medicare provider enrollment standards and safeguards.
Sec. 604. Tracking banned providers across State lines.

1 **SEC. 2. REPEAL OF THE PATIENT PROTECTION AND AF-**
2 **FORDABLE CARE ACT AND THE HEALTH**
3 **CARE AND EDUCATION RECONCILIATION ACT**
4 **OF 2010.**

5 (a) PATIENT PROTECTION AND AFFORDABLE CARE
6 ACT.—The Patient Protection and Affordable Care Act
7 (Public Law 111–148) is repealed and the provisions of
8 law amended or repealed by such Act are restored or re-
9 vived as if such Act had not been enacted.

10 (b) HEALTH CARE AND EDUCATION RECONCILI-
11 ATION ACT OF 2010.—The Health Care and Education
12 Reconciliation Act of 2010 (Public Law 111–152) is re-
13 pealed and the provisions of law amended or repealed by
14 such Act are restored or revived as if such Act had not
15 been enacted.

DIVISION A—ENSURING COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

SEC. 101. ESTABLISH UNIVERSAL ACCESS PROGRAMS TO IMPROVE HIGH RISK POOLS AND REINSURANCE MARKETS.

(a) STATE REQUIREMENT.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, each State shall—

(A) subject to paragraph (3), operate a qualifying State high risk pool described in subsection (b)(1); and

(B) subject to paragraph (3), apply to the operation of such a program from State funds an amount equivalent to the portion of State funds derived from State premium assessments (as defined by the Secretary) that are not otherwise used on State health care programs.

(2) RELATION TO CURRENT QUALIFIED HIGH RISK POOL PROGRAM.—

(A) STATES NOT OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that

1 is not operating a current section 2745 quali-
2 fied high risk pool as of the date of the enact-
3 ment of this Act, the State's operation of a
4 qualifying State high risk pool described in sub-
5 section (b)(1) shall be treated, for purposes of
6 section 2745 of the Public Health Service Act,
7 as the operation of a qualified high risk pool de-
8 scribed in such section.

9 (B) STATE OPERATING A QUALIFIED HIGH
10 RISK POOL.—In the case of a State that is op-
11 erating a current section 2745 qualified high
12 risk pool as of the date of the enactment of this
13 Act, as of the date that is 90 days after the
14 date of the enactment of this Act, such a pool
15 shall not be treated as a qualified high risk pool
16 under section 2745 of the Public Health Service
17 Act unless the pool is a qualifying State high
18 risk pool described in subsection (b)(1).

19 (3) APPLICATION OF FUNDS.—If the pool oper-
20 ated under paragraph (1)(A) is in strong fiscal
21 health, as determined in accordance with standards
22 established by the National Association of Insurance
23 Commissioners and as approved by the State Insur-
24 ance Commissioner involved, the requirement of
25 paragraph (1)(B) shall be deemed to be met.

1 (b) QUALIFYING STATE HIGH RISK POOL.—
2 (1) IN GENERAL.—A qualifying State high risk
3 pool described in this subsection means a current
4 section 2745 qualified high risk pool that meets the
5 following requirements:
6 (A) The pool must be funded with a stable
7 funding source.
8 (B) The pool must eliminate any waiting
9 lists so that all eligible residents who are seek-
10 ing coverage through the pool should be allowed
11 to receive coverage through the pool.
12 (C) The pool must allow for coverage of in-
13 dividuals who, but for the 24-month disability
14 waiting period under section 226(b) of the So-
15 cial Security Act, would be eligible for Medicare
16 during the period of such waiting period.
17 (D) The pool must limit the pool premiums
18 to no more than 150 percent of the average
19 premium for applicable standard risk rates in
20 that State.
21 (E) The pool must conduct education and
22 outreach initiatives so that residents and bro-
23 kers understand that the pool is available to eli-
24 gible residents.

1 (F) The pool must provide coverage for
2 preventive services and disease management for
3 chronic diseases.
4 (G) Subject to subparagraph (C), an indi-
5 vidual may only be eligible for coverage through
6 the pool if the individual has a pre-existing con-
7 dition, as determined in a manner consistent
8 with guidance ussed by the Secretary of Health
9 and Human Services and—
10 (i) was denied health insurance cov-
11 erage in the individual market because of
12 a pre-existing condition or health status; or
13 (ii) was offered such coverage—
14 (I) under terms that limit the
15 coverage for such a pre-existing condi-
16 tion; or
17 (II) at a premium rate that is
18 above the premium rate for coverage
19 through the pool pursuant to this sec-
20 tion.
21 (H) No pre-existing condition exclusion pe-
22 riod may be imposed on coverage through the
23 pool.
24 (I) The pool shall not require an individual
25 to be uninsured for any period as a condition

1 of eligibility to receive coverage through the
2 pool.
3 (2) VERIFICATION OF CITIZENSHIP OR ALIEN
4 QUALIFICATION.—
5 (A) IN GENERAL.—Notwithstanding any
6 other provision of law, only citizens and nation-
7 als of the United States shall be eligible to par-
8 ticipate in a qualifying State high risk pool that
9 receives funds under section 2745 of the Public
10 Health Service Act or this section.
11 (B) CONDITION OF PARTICIPATION.—As a
12 condition of a State receiving such funds, the
13 Secretary shall require the State to certify, to
14 the satisfaction of the Secretary, that such
15 State requires all applicants for coverage in the
16 qualifying State high risk pool to provide satis-
17 factory documentation of citizenship or nation-
18 ality in a manner consistent with section
19 1903(x) of the Social Security Act.
20 (C) RECORDS.—The Secretary shall keep
21 sufficient records such that a determination of
22 citizenship or nationality only has to be made
23 once for any individual under this paragraph.
24 (3) RELATION TO SECTION 2745.—As of Janu-
25 ary 1, 2012, a pool shall not qualify as qualified

1 high risk pool under section 2745 of the Public
2 Health Service Act unless the pool is a qualifying
3 State high risk pool described in paragraph (1).
4 (c) WAIVERS.—In order to accommodate new and in-
5 novative programs, the Secretary may waive such require-
6 ments of this section for qualifying State high risk pools
7 as the Secretary deems appropriate.
8 (d) FUNDING.—In addition to any other amounts ap-
9 propriated, there is appropriated to carry out section 2745
10 of the Public Health Service Act (including through a pool
11 described in subsection (a)(1))—
12 (1) $15,000,000,000 for the period of fiscal
13 years 2011 through 2021; and
14 (2) an additional $10,000,000,000 for the pe-
15 riod of fiscal years 2017 through 2021.
16 (e) DEFINITIONS.—In this section:
17 (1) HEALTH INSURANCE COVERAGE; HEALTH
18 INSURANCE ISSUER.—The terms ''health insurance
19 coverage'' and ''health insurance issuer'' have the
20 meanings given such terms in section 2791 of the
21 Public Health Service Act.
22 (2) CURRENT SECTION 2745 QUALIFIED HIGH
23 RISK POOL.—The term ''current section 2745 quali-
24 fied high risk pool'' has the meaning given the term
25 ''qualified high risk pool'' under section 2745(g) of

1 the Public Health Service Act as in effect as of the
2 date of the enactment of this Act.
3 (3) SECRETARY.—The term ''Secretary'' means
4 Secretary of Health and Human Services.
5 (4) STANDARD RISK RATE.—The term ''stand-
6 ard risk rate'' means a rate that—
7 (A) is determined under the State high
8 risk pool by considering the premium rates
9 charged by other health insurance issuers offer-
10 ing health insurance coverage to individuals in
11 the insurance market served;
12 (B) is established using reasonable actu-
13 arial techniques; and
14 (C) reflects anticipated claims experience
15 and expenses for the coverage involved.
16 (5) STATE.—The term ''State'' means any of
17 the 50 States or the District of Columbia.
18 **SEC. 102. NO ANNUAL OR LIFETIME SPENDING CAPS.**
19 Notwithstanding any other provision of law, a health
20 insurance issuer (including an entity licensed to sell insur-
21 ance with respect to a State or group health plan) may
22 not apply an annual or lifetime aggregate spending cap
23 on any health insurance coverage or plan offered by such
24 issuer.

1 **SEC. 103. PREVENTING UNJUST CANCELLATION OF INSUR-**
2 **ANCE COVERAGE.**

3 (a) CLARIFICATION REGARDING APPLICATION OF
4 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH
5 INSURANCE COVERAGE.—Section 2742 of the Public
6 Health Service Act (42 U.S.C. 300gg–42), as restored by
7 section 2, is amended—

8 (1) in its heading, by inserting "**, CONTINU-**
9 **ATION IN FORCE, INCLUDING PROHIBITION OF**
10 **RESCISSION,**" after "**GUARANTEED RENEW-**
11 **ABILITY**";

12 (2) in subsection (a), by inserting ", including
13 without rescission," after "continue in force"; and

14 (3) in subsection (b)(2), by inserting before the
15 period at the end the following: ", including inten-
16 tional concealment of material facts regarding a
17 health condition related to the condition for which
18 coverage is being claimed".

19 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL
20 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1
21 of part B of title XXVII of the Public Health Service Act,
22 as restored by section 2, is amended by adding at the end
23 the following new section:

1 **"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**
2 **THIRD PARTY REVIEW IN CERTAIN CASES.**

3 ''(a) NOTICE AND REVIEW RIGHT.—If a health in-
4 surance issuer determines to nonrenew or not continue in
5 force, including rescind, health insurance coverage for an
6 individual in the individual market on the basis described
7 in section 2742(b)(2) before such nonrenewal, discontinu-
8 ation, or rescission, may take effect the issuer shall pro-
9 vide the individual with notice of such proposed non-
10 renewal, discontinuation, or rescission and an opportunity
11 for a review of such determination by an independent, ex-
12 ternal third party under procedures specified by the Sec-
13 retary.

14 ''(b) INDEPENDENT DETERMINATION.—If the indi-
15 vidual requests such review by an independent, external
16 third party of a nonrenewal, discontinuation, or rescission
17 of health insurance coverage, the coverage shall remain in
18 effect until such third party determines that the coverage
19 may be nonrenewed, discontinued, or rescinded under sec-
20 tion 2742(b)(2).''.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply after the date of the enactment
23 of this Act with respect to health insurance coverage
24 issued before, on, or after such date.

DIVISION B—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Subtitle A—Enhanced Marketplace Pools

SEC. 201. RULES GOVERNING ENHANCED MARKETPLACE POOLS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974, as restored by section 2, is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ENHANCED MARKETPLACE POOLS

"SEC. 801. SMALL BUSINESS HEALTH PLANS.

"(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

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

1 “(1) is organized and maintained in good faith,
2 with a constitution and bylaws specifically stating its
3 purpose and providing for periodic meetings on at
4 least an annual basis, as a bona fide trade associa-
5 tion, a bona fide industry association (including a
6 rural electric cooperative association or a rural tele-
7 phone cooperative association), a bona fide profes-
8 sional association, or a bona fide chamber of com-
9 merce (or similar bona fide business association, in-
10 cluding a corporation or similar organization that
11 operates on a cooperative basis (within the meaning
12 of section 1381 of the Internal Revenue Code of
13 1986)), for substantial purposes other than that of
14 obtaining medical care;
15 “(2) is established as a permanent entity which
16 receives the active support of its members and re-
17 quires for membership payment on a periodic basis
18 of dues or payments necessary to maintain eligibility
19 for membership;
20 “(3) does not condition membership, such dues
21 or payments, or coverage under the plan on the
22 basis of health status-related factors with respect to
23 the employees of its members (or affiliated mem-
24 bers), or the dependents of such employees, and does

not condition such dues or payments on the basis of group health plan participation; and

"(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary, not later than 1 year after the date of enactment of this part, shall promulgate regulations that apply the rules and standards of this part, as necessary, to circumstances in which a pooling entity other (hereinafter 'Alternative Market Pooling Organizations') is not made up principally of employers and their employees, or not a professional organization or such small business health plan entity identified in section 801.

"(b) ADAPTION OF STANDARDS.—In developing and promulgating regulations pursuant to subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, small business health plans, small and large employers, large and small insurance issuers, consumer representatives, and state insurance commissioners, shall—

1 “(1) adapt the standards of this part, to the
2 maximum degree practicable, to assure balanced and
3 comparable oversight standards for both small busi-
4 ness health plans and alternative market pooling or-
5 ganizations;

6 “(2) permit the participation as alternative
7 market pooling organizations unions, churches and
8 other faith-based organizations, or other organiza-
9 tions composed of individuals and groups which may
10 have little or no association with employment, pro-
11 vided however, that such alternative market pooling
12 organizations meet, and continue meeting on an on-
13 going basis, to satisfy standards, rules, and require-
14 ments materially equivalent to those set forth in this
15 part with respect to small business health plans;

16 “(3) conduct periodic verification of such com-
17 pliance by alternative market pooling organizations,
18 in consultation with the Secretary of Health and
19 Human Services and the National Association of In-
20 surance Commissioners, except that such periodic
21 verification shall not materially impede market entry
22 or participation as pooling entities comparable to
23 that of small business health plans;

24 “(4) assure that consistent, clear, and regularly
25 monitored standards are applied with respect to al-

ternative market pooling organizations to avert material risk-selection within or among the composition of such organizations;

"(5) the expedited and deemed certification procedures provided in section 805(d) shall not apply to alternative market pooling organizations until sooner of the promulgation of regulations under this subsection or the expiration of one year following enactment of this Act; and

"(6) make such other appropriate adjustments to the requirements of this part as the Secretary may reasonably deem appropriate to fit the circumstances of an individual alternative market pooling organization or category of such organization, including but not limited to the application of the membership payment requirements of section 801(b)(2) to alternative market pooling organizations composed primarily of church- or faith-based membership.

"SEC. 803. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

"(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business

1 health plans which apply for certification as meeting the
2 requirements of this part.

3 "(b) REQUIREMENTS APPLICABLE TO CERTIFIED
4 PLANS.—A small business health plan with respect to
5 which certification under this part is in effect shall meet
6 the applicable requirements of this part, effective on the
7 date of certification (or, if later, on the date on which the
8 plan is to commence operations).

9 "(c) REQUIREMENTS FOR CONTINUED CERTIFI-
10 CATION.—The applicable authority may provide by regula-
11 tion for continued certification of small business health
12 plans under this part. Such regulation shall provide for
13 the revocation of a certification if the applicable authority
14 finds that the small business health plan involved is failing
15 to comply with the requirements of this part.

16 "(d) EXPEDITED AND DEEMED CERTIFICATION.—

17 "(1) IN GENERAL.—If the Secretary fails to act
18 on an application for certification under this section
19 within 90 days of receipt of such application, the ap-
20 plying small business health plan shall be deemed
21 certified until such time as the Secretary may deny
22 for cause the application for certification.

23 "(2) CIVIL PENALTY.—The Secretary may as-
24 sess a civil penalty against the board of trustees and
25 plan sponsor (jointly and severally) of a small busi-

1 ness health plan that is deemed certified under para-
2 graph (1) of up to $500,000 in the event the Sec-
3 retary determines that the application for certifi-
4 cation of such small business health plan was will-
5 fully or with gross negligence incomplete or inac-
6 curate.

7 **"SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND**
8 **BOARDS OF TRUSTEES.**

9 "(a) SPONSOR.—The requirements of this subsection
10 are met with respect to a small business health plan if
11 the sponsor has met (or is deemed under this part to have
12 met) the requirements of section 801(b) for a continuous
13 period of not less than 3 years ending with the date of
14 the application for certification under this part.

15 "(b) BOARD OF TRUSTEES.—The requirements of
16 this subsection are met with respect to a small business
17 health plan if the following requirements are met:

18 "(1) FISCAL CONTROL.—The plan is operated,
19 pursuant to a plan document, by a board of trustees
20 which pursuant to a trust agreement has complete
21 fiscal control over the plan and which is responsible
22 for all operations of the plan.

23 "(2) RULES OF OPERATION AND FINANCIAL
24 CONTROLS.—The board of trustees has in effect
25 rules of operation and financial controls, based on a

1 3-year plan of operation, adequate to carry out the
2 terms of the plan and to meet all requirements of
3 this title applicable to the plan.

4 "(3) RULES GOVERNING RELATIONSHIP TO
5 PARTICIPATING EMPLOYERS AND TO CONTRAC-
6 TORS.—

7 "(A) BOARD MEMBERSHIP.—

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

16 "(ii) LIMITATION.—

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

23 "(II) LIMITED EXCEPTION FOR
24 PROVIDERS OF SERVICES SOLELY ON
25 BEHALF OF THE SPONSOR.—Officers

or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

"(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of this part.

"(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers.

1 "(c) TREATMENT OF FRANCHISES.—In the case of
2 a group health plan which is established and maintained
3 by a franchiser for a franchisor or for its franchisees—
4 "(1) the requirements of subsection (a) and sec-
5 tion 801(a) shall be deemed met if such require-
6 ments would otherwise be met if the franchisor were
7 deemed to be the sponsor referred to in section
8 801(b) and each franchisee were deemed to be a
9 member (of the sponsor) referred to in section
10 801(b); and
11 "(2) the requirements of section 804(a)(1) shall
12 be deemed met.
13 For purposes of this subsection the terms 'franchisor' and
14 'franchisee' shall have the meanings given such terms for
15 purposes of sections 436.2(a) through 436.2(c) of title 16,
16 Code of Federal Regulations (including any such amend-
17 ments to such regulation after the date of enactment of
18 this part).

19 **"SEC. 805. PARTICIPATION AND COVERAGE REQUIRE-**
20 **MENTS.**

21 "(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
22 requirements of this subsection are met with respect to
23 a small business health plan if, under the terms of the
24 plan—
25 "(1) each participating employer must be—

1 "(A) a member of the sponsor;
2 "(B) the sponsor; or
3 "(C) an affiliated member of the sponsor,
4 except that, in the case of a sponsor which is
5 a professional association or other individual-
6 based association, if at least one of the officers,
7 directors, or employees of an employer, or at
8 least one of the individuals who are partners in
9 an employer and who actively participates in
10 the business, is a member or such an affiliated
11 member of the sponsor, participating employers
12 may also include such employer; and
13 "(2) all individuals commencing coverage under
14 the plan after certification under this part must
15 be—
16 "(A) active or retired owners (including
17 self-employed individuals), officers, directors, or
18 employees of, or partners in, participating em-
19 ployers; or
20 "(B) the dependents of individuals de-
21 scribed in subparagraph (A).
22 "(b) INDIVIDUAL MARKET UNAFFECTED.—The re-
23 quirements of this subsection are met with respect to a
24 small business health plan if, under the terms of the plan,
25 no participating employer may provide health insurance

1 coverage in the individual market for any employee not
2 covered under the plan which is similar to the coverage
3 contemporaneously provided to employees of the employer
4 under the plan, if such exclusion of the employee from cov-
5 erage under the plan is based on a health status-related
6 factor with respect to the employee and such employee
7 would, but for such exclusion on such basis, be eligible
8 for coverage under the plan.

9 ''(c) PROHIBITION OF DISCRIMINATION AGAINST EM-
10 PLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—
11 The requirements of this subsection are met with respect
12 to a small business health plan if—

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

21 ''(2) information regarding all coverage options
22 available under the plan is made readily available to
23 any employer eligible to participate; and

24 ''(3) the applicable requirements of sections
25 701, 702, and 703 are met with respect to the plan.

1 **"SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN**
2 **DOCUMENTS, CONTRIBUTION RATES, AND**
3 **BENEFIT OPTIONS.**
4 ''(a) IN GENERAL.—The requirements of this section
5 are met with respect to a small business health plan if
6 the following requirements are met:
7 ''(1) CONTENTS OF GOVERNING INSTRU-
8 MENTS.—
9 ''(A) IN GENERAL.—The instruments gov-
10 erning the plan include a written instrument,
11 meeting the requirements of an instrument re-
12 quired under section 402(a)(1), which—
13 ''(i) provides that the board of trust-
14 ees serves as the named fiduciary required
15 for plans under section 402(a)(1) and
16 serves in the capacity of a plan adminis-
17 trator (referred to in section 3(16)(A));
18 and
19 ''(ii) provides that the sponsor of the
20 plan is to serve as plan sponsor (referred
21 to in section 3(16)(B)).
22 ''(B) DESCRIPTION OF MATERIAL PROVI-
23 SIONS.—The terms of the health insurance cov-
24 erage (including the terms of any individual
25 certificates that may be offered to individuals in
26 connection with such coverage) describe the ma-

1 terial benefit and rating, and other provisions
2 set forth in this section and such material pro-
3 visions are included in the summary plan de-
4 scription.
5 "(2) CONTRIBUTION RATES MUST BE NON-
6 DISCRIMINATORY.—
7 "(A) IN GENERAL.—The contribution rates
8 for any participating small employer shall not
9 vary on the basis of any health status-related
10 factor in relation to employees of such employer
11 or their beneficiaries and shall not vary on the
12 basis of the type of business or industry in
13 which such employer is engaged, subject to sub-
14 paragraph (B) and the terms of this title.
15 "(B) EFFECT OF TITLE.—Nothing in this
16 title or any other provision of law shall be con-
17 strued to preclude a health insurance issuer of-
18 fering health insurance coverage in connection
19 with a small business health plan that meets
20 the requirements of this part, and at the re-
21 quest of such small business health plan,
22 from—
23 "(i) setting contribution rates for the
24 small business health plan based on the
25 claims experience of the small business

1 health plan so long as any variation in
2 such rates for participating small employ-
3 ers complies with the requirements of
4 clause (ii), except that small business
5 health plans shall not be subject, in non-
6 adopting states, to subparagraphs (A)(ii)
7 and (C) of section 2912(a)(2) of the Public
8 Health Service Act, and in adopting states,
9 to any State law that would have the effect
10 of imposing requirements as outlined in
11 such subparagraphs (A)(ii) and (C); or
12 ''(ii) varying contribution rates for
13 participating small employers in a small
14 business health plan in a State to the ex-
15 tent that such rates could vary using the
16 same methodology employed in such State
17 for regulating small group premium rates,
18 subject to the terms of part I of subtitle A
19 of title XXXI of the Public Health Service
20 Act (relating to rating requirements), as
21 added by subtitle B of title II of the
22 Health Security for All Americans Act of
23 2010.
24 ''(3) EXCEPTIONS REGARDING SELF-EMPLOYED
25 AND LARGE EMPLOYERS.—

1 "(A) SELF-EMPLOYED.—
2 "(i) IN GENERAL.—Small business
3 health plans with participating employers
4 who are self-employed individuals (and
5 their dependents) shall enroll such self-em-
6 ployed participating employers in accord-
7 ance with rating rules that do not violate
8 the rating rules for self-employed individ-
9 uals in the State in which such self-em-
10 ployed participating employers are located.
11 "(ii) GUARANTEE ISSUE.—Small busi-
12 ness health plans with participating em-
13 ployers who are self-employed individuals
14 (and their dependents) may decline to
15 guarantee issue to such participating em-
16 ployers in States in which guarantee issue
17 is not otherwise required for the self-em-
18 ployed in that State.
19 "(B) LARGE EMPLOYERS.—Small business
20 health plans with participating employers that
21 are larger than small employers (as defined in
22 section 808(a)(10)) shall enroll such large par-
23 ticipating employers in accordance with rating
24 rules that do not violate the rating rules for

1 large employers in the State in which such large
2 participating employers are located.

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

8 "(b) ABILITY OF SMALL BUSINESS HEALTH PLANS
9 TO DESIGN BENEFIT OPTIONS.—Nothing in this part or
10 any provision of State law (as defined in section
11 514(c)(1)) shall be construed to preclude a small business
12 health plan or a health insurance issuer offering health
13 insurance coverage in connection with a small business
14 health plan from exercising its sole discretion in selecting
15 the specific benefits and services consisting of medical care
16 to be included as benefits under such plan or coverage,
17 except that such benefits and services must meet the terms
18 and specifications of part II of subtitle A of title XXXI
19 of the Public Health Service Act (relating to lower cost
20 plans), as added by subtitle B of title II of the Health
21 Security for All Americans Act of 2010.

22 "(c) DOMICILE AND NON-DOMICILE STATES.—

23 "(1) DOMICILE STATE.—Coverage shall be
24 issued to a small business health plan in the State

1 in which the sponsor's principal place of business is
2 located.

3 "(2) NON-DOMICILE STATES.—With respect to
4 a State (other than the domicile State) in which par-
5 ticipating employers of a small business health plan
6 are located but in which the insurer of the small
7 business health plan in the domicile State is not yet
8 licensed, the following shall apply:

9 "(A) TEMPORARY PREEMPTION.—If, upon
10 the expiration of the 90-day period following
11 the submission of a licensure application by
12 such insurer (that includes a certified copy of
13 an approved licensure application as submitted
14 by such insurer in the domicile State) to such
15 State, such State has not approved or denied
16 such application, such State's health insurance
17 licensure laws shall be temporarily preempted
18 and the insurer shall be permitted to operate in
19 such State, subject to the following terms:

20 "(i) APPLICATION OF NON-DOMICILE
21 STATE LAW.—Except with respect to licen-
22 sure and with respect to the terms of sub-
23 title A of title XXXI of the Public Health
24 Service Act (relating to rating and benefits
25 as added by subtitle B of title II of the

1 Health Security for All Americans Act of
2 2010), the laws and authority of the non-
3 domicile State shall remain in full force
4 and effect.

5 "(ii) REVOCATION OF PREEMPTION.—
6 The preemption of a non-domicile State's
7 health insurance licensure laws pursuant to
8 this subparagraph, shall be terminated
9 upon the occurrence of either of the fol-
10 lowing:

11 "(I) APPROVAL OR DENIAL OF
12 APPLICATION.—The approval of denial
13 of an insurer's licensure application,
14 following the laws and regulations of
15 the non-domicile State with respect to
16 licensure.

17 "(II) DETERMINATION OF MATE-
18 RIAL VIOLATION.—A determination by
19 a non-domicile State that an insurer
20 operating in a non-domicile State pur-
21 suant to the preemption provided for
22 in this subparagraph is in material
23 violation of the insurance laws (other
24 than licensure and with respect to the
25 terms of subtitle A of title XXXI of

the Public Health Service Act (relating to rating and benefits added by subtitle B of title II of the Health Security for All Americans Act of 2010)) of such State.

"(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

"(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in each State in which the small business health plans operate.

"(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed

1 insurer in that State, even where such insurer
2 is not the insurer of such small business health
3 plan in the State in which such small business
4 health plan is domiciled.

5 **"SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
6 **LATED REQUIREMENTS.**

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

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

22 "(1) IDENTIFYING INFORMATION.—The names
23 and addresses of—

24 "(A) the sponsor; and

1 "(B) the members of the board of trustees
2 of the plan.
3 "(2) STATES IN WHICH PLAN INTENDS TO DO
4 BUSINESS.—The States in which participants and
5 beneficiaries under the plan are to be located and
6 the number of them expected to be located in each
7 such State.
8 "(3) BONDING REQUIREMENTS.—Evidence pro-
9 vided by the board of trustees that the bonding re-
10 quirements of section 412 will be met as of the date
11 of the application or (if later) commencement of op-
12 erations.
13 "(4) PLAN DOCUMENTS.—A copy of the docu-
14 ments governing the plan (including any bylaws and
15 trust agreements), the summary plan description,
16 and other material describing the benefits that will
17 be provided to participants and beneficiaries under
18 the plan.
19 "(5) AGREEMENTS WITH SERVICE PRO-
20 VIDERS.—A copy of any agreements between the
21 plan, health insurance issuer, and contract adminis-
22 trators and other service providers.
23 "(c) FILING NOTICE OF CERTIFICATION WITH
24 STATES.—A certification granted under this part to a
25 small business health plan shall not be effective unless

written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

"(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

"(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

1 "(2) develops a plan for winding up the affairs
2 of the plan in connection with such termination in
3 a manner which will result in timely payment of all
4 benefits for which the plan is obligated; and
5 "(3) submits such plan in writing to the appli-
6 cable authority.
7 Actions required under this section shall be taken in such
8 form and manner as may be prescribed by the applicable
9 authority by regulation.

10 **"SEC. 809. IMPLEMENTATION AND APPLICATION AUTHOR-**
11 **ITY BY SECRETARY.**

12 "The Secretary shall, through promulgation and im-
13 plementation of such regulations as the Secretary may
14 reasonably determine necessary or appropriate, and in
15 consultation with a balanced spectrum of effected entities
16 and persons, modify the implementation and application
17 of this part to accommodate with minimum disruption
18 such changes to State or Federal law provided in this part
19 and the (and the amendments made by such Act) or in
20 regulations issued thereto.

21 **"SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.**

22 "(a) DEFINITIONS.—For purposes of this part—
23 "(1) AFFILIATED MEMBER.—The term 'affili-
24 ated member' means, in connection with a sponsor—

1 ''(A) a person who is otherwise eligible to
2 be a member of the sponsor but who elects an
3 affiliated status with the sponsor, or
4 ''(B) in the case of a sponsor with mem-
5 bers which consist of associations, a person who
6 is a member or employee of any such associa-
7 tion and elects an affiliated status with the
8 sponsor.
9 ''(2) APPLICABLE AUTHORITY.—The term 'ap-
10 plicable authority' means the Secretary of Labor, ex-
11 cept that, in connection with any exercise of the Sec-
12 retary's authority with respect to which the Sec-
13 retary is required under section 506(d) to consult
14 with a State, such term means the Secretary, in con-
15 sultation with such State.
16 ''(3) 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 ''(4) GROUP HEALTH PLAN.—The term 'group
24 health plan' has the meaning provided in section

1 733(a)(1) (after applying subsection (b) of this sec-
2 tion).

3 "(5) HEALTH INSURANCE COVERAGE.—The
4 term 'health insurance coverage' has the meaning
5 provided in section 733(b)(1), except that such term
6 shall not include excepted benefits (as defined in sec-
7 tion 733(c)).

8 "(6) HEALTH INSURANCE ISSUER.—The term
9 'health insurance issuer' has the meaning provided
10 in section 733(b)(2).

11 "(7) INDIVIDUAL MARKET.—

12 "(A) IN GENERAL.—The term 'individual
13 market' means the market for health insurance
14 coverage offered to individuals other than in
15 connection with a group health plan.

16 "(B) TREATMENT OF VERY SMALL
17 GROUPS.—

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

1 "(ii) STATE EXCEPTION.—Clause (i)
2 shall not apply in the case of health insur-
3 ance coverage offered in a State if such
4 State regulates the coverage described in
5 such clause in the same manner and to the
6 same extent as coverage in the small group
7 market (as defined in section 2791(e)(5) of
8 the Public Health Service Act) is regulated
9 by such State.

10 "(8) MEDICAL CARE.—The term 'medical care'
11 has the meaning provided in section 733(a)(2).

12 "(9) PARTICIPATING EMPLOYER.—The term
13 'participating employer' means, in connection with a
14 small business health plan, any employer, if any in-
15 dividual who is an employee of such employer, a
16 partner in such employer, or a self-employed indi-
17 vidual who is such employer (or any dependent, as
18 defined under the terms of the plan, of such indi-
19 vidual) is or was covered under such plan in connec-
20 tion with the status of such individual as such an
21 employee, partner, or self-employed individual in re-
22 lation to the plan.

23 "(10) SMALL EMPLOYER.—The term 'small em-
24 ployer' means, in connection with a group health

1 plan with respect to a plan year, a small employer
2 as defined in section 2791(e)(4).

3 "(11) TRADE ASSOCIATION AND PROFESSIONAL
4 ASSOCIATION.—The terms 'trade association' and
5 'professional association' mean an entity that meets
6 the requirements of section 1.501(c)(6)–1 of title 26,
7 Code of Federal Regulations (as in effect on the
8 date of enactment of this Act).

9 "(b) RULE OF CONSTRUCTION.—For purposes of de-
10 termining whether a plan, fund, or program is an em-
11 ployee welfare benefit plan which is a small business
12 health plan, and for purposes of applying this title in con-
13 nection with such plan, fund, or program so determined
14 to be such an employee welfare benefit plan—

15 "(1) in the case of a partnership, the term 'em-
16 ployer' (as defined in section 3(5)) includes the part-
17 nership in relation to the partners, and the term
18 'employee' (as defined in section 3(6)) includes any
19 partner in relation to the partnership; and

20 "(2) in the case of a self-employed individual,
21 the term 'employer' (as defined in section 3(5)) and
22 the term 'employee' (as defined in section 3(6)) shall
23 include such individual.

24 "(c) RENEWAL.—Notwithstanding any provision of
25 law to the contrary, a participating employer in a small

1 business health plan shall not be deemed to be a plan
2 sponsor in applying requirements relating to coverage re-
3 newal.

4 ‘‘(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this
5 part shall be construed to create any mandates for cov-
6 erage of benefits for HSA-qualified health plans that
7 would require reimbursements in violation of section
8 223(c)(2) of the Internal Revenue Code of 1986.’’.

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

11 (1) Section 514(b)(6) of such Act (29 U.S.C.
12 1144(b)(6)), as restored by section 2, is amended by
13 adding at the end the following new subparagraph:
14 ‘‘(E) The preceding subparagraphs of this paragraph
15 do not apply with respect to any State law in the case
16 of a small business health plan which is certified under
17 part 8.’’.

18 (2) Section 514 of such Act (29 U.S.C. 1144),
19 as restored by section 2, is amended—

20 (A) in subsection (b)(4), by striking ‘‘Sub-
21 section (a)’’ and inserting ‘‘Subsections (a) and
22 (d)’’;

23 (B) in subsection (b)(5), by striking ‘‘sub-
24 section (a)’’ in subparagraph (A) and inserting
25 ‘‘subsection (a) of this section and subsections

1 (a)(2)(B) and (b) of section 805'', and by strik-
2 ing ''subsection (a)'' in subparagraph (B) and
3 inserting ''subsection (a) of this section or sub-
4 section (a)(2)(B) or (b) of section 805'';
5 (C) by redesignating subsection (d) as sub-
6 section (e); and
7 (D) by inserting after subsection (c) the
8 following new subsection:
9 ''(d)(1) Except as provided in subsection (b)(4), the
10 provisions of this title shall supersede any and all State
11 laws insofar as they may now or hereafter preclude a
12 health insurance issuer from offering health insurance cov-
13 erage in connection with a small business health plan
14 which is certified under part 8.
15 ''(2) In any case in which health insurance coverage
16 of any policy type is offered under a small business health
17 plan certified under part 8 to a participating employer op-
18 erating in such State, the provisions of this title shall su-
19 persede any and all laws of such State insofar as they may
20 establish rating and benefit requirements that would oth-
21 erwise apply to such coverage, provided the requirements
22 of subtitle A of title XXXI of the Public Health Service
23 Act (as added by title II of the Health Security for All
24 Americans Act of 2010) (concerning health plan rating
25 and benefits) are met.''.

1 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
2 (29 U.S.C. 102(16)(B)), as restored by section 2, is
3 amended by adding at the end the following new sentence:
4 "Such term also includes a person serving as the sponsor
5 of a small business health plan under part 8.".
6 (d) SAVINGS CLAUSE.—Section 731(c) of such Act,
7 as restored by section 2, is amended by inserting "or part
8 8" after "this part".
9 (e) CLERICAL AMENDMENT.—The table of contents
10 in section 1 of the Employee Retirement Income Security
11 Act of 1974, as restored by section 2, is amended by in-
12 serting after the item relating to section 734 the following
13 new items:

"PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

"801. Small business health plans.
"802. Alternative market pooling organizations.
"803. Certification of small business health plans.
"804. Requirements relating to sponsors and boards of trustees.
"805. Participation and coverage requirements.
"806. Other requirements relating to plan documents, contribution rates, and benefit options.
"807. Requirements for application and related requirements.
"808. Notice requirements for voluntary termination.
"809. Implementation and application authority by Secretary.
"810. Definitions and rules of construction.".

14 **SEC. 202. COOPERATION BETWEEN FEDERAL AND STATE**
15 **AUTHORITIES.**

16 Section 506 of the Employee Retirement Income Se-
17 curity Act of 1974 (29 U.S.C. 1136), as restored by sec-
18 tion 2, is amended by adding at the end the following new
19 subsection:

1 "(d) CONSULTATION WITH STATES WITH RESPECT
2 TO SMALL BUSINESS HEALTH PLANS.—
3 "(1) AGREEMENTS WITH STATES.—The Sec-
4 retary shall consult with the State recognized under
5 paragraph (2) with respect to a small business
6 health plan regarding the exercise of—
7 "(A) the Secretary's authority under sec-
8 tions 502 and 504 to enforce the requirements
9 for certification under part 8; and
10 "(B) the Secretary's authority to certify
11 small business health plans under part 8 in ac-
12 cordance with regulations of the Secretary ap-
13 plicable to certification under part 8.
14 "(2) RECOGNITION OF DOMICILE STATE.—In
15 carrying out paragraph (1), the Secretary shall en-
16 sure that only one State will be recognized, with re-
17 spect to any particular small business health plan,
18 as the State with which consultation is required. In
19 carrying out this paragraph such State shall be the
20 domicile State, as defined in section 805(c).".
21 **SEC. 203. EFFECTIVE DATE AND TRANSITIONAL AND**
22 **OTHER RULES.**
23 (a) EFFECTIVE DATE.—The amendments made by
24 this subtitle shall take effect 12 months after the date of
25 the enactment of this Act. The Secretary of Labor shall

1 first issue all regulations necessary to carry out the
2 amendments made by this subtitle within 6 months after
3 the date of the enactment of this Act.

4 (b) TREATMENT OF CERTAIN EXISTING HEALTH
5 BENEFITS PROGRAMS.—

6 (1) IN GENERAL.—In any case in which, as of
7 the date of the enactment of this Act, an arrange-
8 ment is maintained in a State for the purpose of
9 providing benefits consisting of medical care for the
10 employees and beneficiaries of its participating em-
11 ployers, at least 200 participating employers make
12 contributions to such arrangement, such arrange-
13 ment has been in existence for at least 10 years, and
14 such arrangement is licensed under the laws of one
15 or more States to provide such benefits to its par-
16 ticipating employers, upon the filing with the appli-
17 cable authority (as defined in section 808(a)(2) of
18 the Employee Retirement Income Security Act of
19 1974 (as amended by this subtitle)) by the arrange-
20 ment of an application for certification of the ar-
21 rangement under part 8 of subtitle B of title I of
22 such Act—

23 (A) such arrangement shall be deemed to
24 be a group health plan for purposes of title I
25 of such Act;

1 (B) the requirements of sections 801(a)
2 and 803(a) of the Employee Retirement Income
3 Security Act of 1974 shall be deemed met with
4 respect to such arrangement;
5 (C) the requirements of section 803(b) of
6 such Act shall be deemed met, if the arrange-
7 ment is operated by a board of trustees which
8 has control over the arrangement;
9 (D) the requirements of section 804(a) of
10 such Act shall be deemed met with respect to
11 such arrangement; and
12 (E) the arrangement may be certified by
13 any applicable authority with respect to its op-
14 erations in any State only if it operates in such
15 State on the date of certification.
16 The provisions of this subsection shall cease to apply
17 with respect to any such arrangement at such time
18 after the date of the enactment of this Act as the
19 applicable requirements of this subsection are not
20 met with respect to such arrangement or at such
21 time that the arrangement provides coverage to par-
22 ticipants and beneficiaries in any State other than
23 the States in which coverage is provided on such
24 date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

Subtitle B—Market Relief

SEC. 204. MARKET RELIEF.

The Public Health Service Act (42 U.S.C. 201 et seq.), as restored by section 2, is amended by inserting after title XXX the following:

''TITLE XXXI—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 3101. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

"SEC. 3102. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

"The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this title to accommodate with minimum disruption such changes to State or Federal law provided in this title and the (and the amendments made by such Act) or in regulations issued thereto.

"Subtitle A—Market Relief

"PART I—RATING REQUIREMENTS

"SEC. 3111. DEFINITIONS.

"In this part:

"(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 3112(a)(1) or, as applicable, transitional small group rating rules set forth in section 3112(b).

"(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials des-

1 ignated by the State to enforce the insurance laws
2 of such State.

3 "(3) BASE PREMIUM RATE.—The term 'base
4 premium rate' means, for each class of business with
5 respect to a rating period, the lowest premium rate
6 charged or that could have been charged under a
7 rating system for that class of business by the small
8 employer carrier to small employers with similar
9 case characteristics for health benefit plans with the
10 same or similar coverage.

11 "(4) ELIGIBLE INSURER.—The term 'eligible
12 insurer' means a health insurance issuer that is li-
13 censed in a State and that—

14 "(A) notifies the Secretary, not later than
15 30 days prior to the offering of coverage de-
16 scribed in this subparagraph, that the issuer in-
17 tends to offer health insurance coverage con-
18 sistent with the Model Small Group Rating
19 Rules or, as applicable, transitional small group
20 rating rules in a State;

21 "(B) notifies the insurance department of
22 a nonadopting State (or other State agency),
23 not later than 30 days prior to the offering of
24 coverage described in this subparagraph, that
25 the issuer intends to offer small group health

1 insurance coverage in that State consistent with
2 the Model Small Group Rating Rules, and pro-
3 vides with such notice a copy of any insurance
4 policy that it intends to offer in the State, its
5 most recent annual and quarterly financial re-
6 ports, and any other information required to be
7 filed with the insurance department of the State
8 (or other State agency); and

9 ''(C) includes in the terms of the health in-
10 surance coverage offered in nonadopting States
11 (including in the terms of any individual certifi-
12 cates that may be offered to individuals in con-
13 nection with such group health coverage) and
14 filed with the State pursuant to subparagraph
15 (B), a description in the insurer's contract of
16 the Model Small Group Rating Rules and an af-
17 firmation that such Rules are included in the
18 terms of such contract.

19 ''(5) HEALTH INSURANCE COVERAGE.—The
20 term 'health insurance coverage' means any coverage
21 issued in the small group health insurance market,
22 except that such term shall not include excepted
23 benefits (as defined in section 2791(c)).

24 ''(6) INDEX RATE.—The term 'index rate'
25 means for each class of business with respect to the

rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

"(7) MODEL SMALL GROUP RATING RULES.—The term 'Model Small Group Rating Rules' means the rules set forth in section 3112(a)(2).

"(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

"(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

"(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

"(11) VARIATION LIMITS.—

"(A) COMPOSITE VARIATION LIMIT.—

"(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State

1 law based on the following factors or case
2 characteristics:
3 ''(I) Age.
4 ''(II) Duration of coverage.
5 ''(III) Claims experience.
6 ''(IV) Health status.
7 ''(ii) USE OF FACTORS.—With respect
8 to the use of the factors described in
9 clause (i) in setting premium rates, a
10 health insurance issuer shall use one or
11 both of the factors described in subclauses
12 (I) or (IV) of such clause and may use the
13 factors described in subclauses (II) or (III)
14 of such clause.
15 ''(B) TOTAL VARIATION LIMIT.—The term
16 'total variation limit' means the total variation
17 in premium rates charged by a health insurance
18 issuer in the small group market as permitted
19 under applicable State law based on all factors
20 and case characteristics (as described in section
21 3112(a)(1)).
22 **''SEC. 3112. RATING RULES.**
23 ''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR
24 PREMIUM VARIATIONS AND MODEL SMALL GROUP RAT-
25 ING RULES.—Not later than 6 months after the date of

1 enactment of this title, the Secretary shall promulgate reg-
2 ulations establishing the following Minimum Standards
3 and Model Small Group Rating Rules:

4 "(1) MINIMUM STANDARDS FOR PREMIUM VARI-
5 ATIONS.—

6 "(A) COMPOSITE VARIATION LIMIT.—The
7 composite variation limit shall not be less than
8 3:1.

9 "(B) TOTAL VARIATION LIMIT.—The total
10 variation limit shall not be less than 5:1.

11 "(C) PROHIBITION ON USE OF CERTAIN
12 CASE CHARACTERISTICS.—For purposes of this
13 paragraph, in calculating the total variation
14 limit, the State shall not use case characteris-
15 tics other than those used in calculating the
16 composite variation limit and industry, geo-
17 graphic area, group size, participation rate,
18 class of business, and participation in wellness
19 programs.

20 "(2) MODEL SMALL GROUP RATING RULES.—
21 The following apply to an eligible insurer in a non-
22 adopting State:

23 "(A) PREMIUM RATES.—Premium rates
24 for small group health benefit plans to which
25 this title applies shall comply with the following

1 provisions relating to premiums, except as pro-
2 vided for under subsection (b):
3 "(i) VARIATION IN PREMIUM
4 RATES.—The plan may not vary premium
5 rates by more than the minimum stand-
6 ards provided for under paragraph (1).
7 "(ii) INDEX RATE.—The index rate
8 for a rating period for any class of busi-
9 ness shall not exceed the index rate for any
10 other class of business by more than 20
11 percent, excluding those classes of business
12 related to association groups under this
13 title.
14 "(iii) CLASS OF BUSINESSES.—With
15 respect to a class of business, the premium
16 rates charged during a rating period to
17 small employers with similar case charac-
18 teristics for the same or similar coverage
19 or the rates that could be charged to such
20 employers under the rating system for that
21 class of business, shall not vary from the
22 index rate by more than 25 percent of the
23 index rate under clause (ii).
24 "(iv) INCREASES FOR NEW RATING
25 PERIODS.—The percentage increase in the

1 premium rate charged to a small employer
2 for a new rating period may not exceed the
3 sum of the following:

4 "(I) The percentage change in
5 the new business premium rate meas-
6 ured from the first day of the prior
7 rating period to the first day of the
8 new rating period. In the case of a
9 health benefit plan into which the
10 small employer carrier is no longer en-
11 rolling new small employers, the small
12 employer carrier shall use the percent-
13 age change in the base premium rate,
14 except that such change shall not ex-
15 ceed, on a percentage basis, the
16 change in the new business premium
17 rate for the most similar health ben-
18 efit plan into which the small em-
19 ployer carrier is actively enrolling new
20 small employers.

21 "(II) Any adjustment, not to ex-
22 ceed 15 percent annually and adjusted
23 pro rata for rating periods of less
24 then 1 year, due to the claim experi-
25 ence, health status or duration of cov-

1 erage of the employees or dependents
2 of the small employer as determined
3 from the small employer carrier's rate
4 manual for the class of business in-
5 volved.

6 "(III) Any adjustment due to
7 change in coverage or change in the
8 case characteristics of the small em-
9 ployer as determined from the small
10 employer carrier's rate manual for the
11 class of business.

12 "(v) UNIFORM APPLICATION OF AD-
13 JUSTMENTS.—Adjustments in premium
14 rates for claim experience, health status, or
15 duration of coverage shall not be charged
16 to individual employees or dependents. Any
17 such adjustment shall be applied uniformly
18 to the rates charged for all employees and
19 dependents of the small employer.

20 "(vi) PROHIBITION ON USE OF CER-
21 TAIN CASE CHARACTERISTIC.—A small em-
22 ployer carrier shall not utilize case charac-
23 teristics, other than those permitted under
24 paragraph (1)(C), without the prior ap-
25 proval of the applicable State authority.

1 "(vii) CONSISTENT APPLICATION OF
2 FACTORS.—Small employer carriers shall
3 apply rating factors, including case charac-
4 teristics, consistently with respect to all
5 small employers in a class of business.
6 Rating factors shall produce premiums for
7 identical groups which differ only by the
8 amounts attributable to plan design and do
9 not reflect differences due to the nature of
10 the groups assumed to select particular
11 health benefit plans.

12 "(viii) TREATMENT OF PLANS AS HAV-
13 ING SAME RATING PERIOD.—A small em-
14 ployer carrier shall treat all health benefit
15 plans issued or renewed in the same cal-
16 endar month as having the same rating pe-
17 riod.

18 "(ix) REQUIRE COMPLIANCE.—Pre-
19 mium rates for small business health ben-
20 efit plans shall comply with the require-
21 ments of this subsection notwithstanding
22 any assessments paid or payable by a small
23 employer carrier as required by a State's
24 small employer carrier reinsurance pro-
25 gram.

1 "(B) ESTABLISHMENT OF SEPARATE
2 CLASS OF BUSINESS.—Subject to subparagraph
3 (C), a small employer carrier may establish a
4 separate class of business only to reflect sub-
5 stantial differences in expected claims experi-
6 ence or administrative costs related to the fol-
7 lowing:
8 "(i) The small employer carrier uses
9 more than one type of system for the mar-
10 keting and sale of health benefit plans to
11 small employers.
12 "(ii) The small employer carrier has
13 acquired a class of business from another
14 small employer carrier.
15 "(iii) The small employer carrier pro-
16 vides coverage to one or more association
17 groups that meet the requirements of this
18 title.
19 "(C) LIMITATION.—A small employer car-
20 rier may establish up to 9 separate classes of
21 business under subparagraph (B), excluding
22 those classes of business related to association
23 groups under this title.
24 "(D) LIMITATION ON TRANSFERS.—A
25 small employer carrier shall not transfer a

1 small employer involuntarily into or out of a
2 class of business. A small employer carrier shall
3 not offer to transfer a small employer into or
4 out of a class of business unless such offer is
5 made to transfer all small employers in the
6 class of business without regard to case charac-
7 teristics, claim experience, health status or du-
8 ration of coverage since issue.

9 "(b) TRANSITIONAL MODEL SMALL GROUP RATING
10 RULES.—

11 "(1) IN GENERAL.—Not later than 6 months
12 after the date of enactment of this title and to the
13 extent necessary to provide for a graduated transi-
14 tion to the minimum standards for premium vari-
15 ation as provided for in subsection (a)(1), the Sec-
16 retary, in consultation with the National Association
17 of Insurance Commissioners (NAIC), shall promul-
18 gate State-specific transitional small group rating
19 rules in accordance with this subsection, which shall
20 be applicable with respect to non-adopting States
21 and eligible insurers operating in such States for a
22 period of not to exceed 3 years from the date of the
23 promulgation of the minimum standards for pre-
24 mium variation pursuant to subsection (a).

1 "(2) COMPLIANCE WITH TRANSITIONAL MODEL
2 SMALL GROUP RATING RULES.—During the transi-
3 tion period described in paragraph (1), a State that,
4 on the date of enactment of this title, has in effect
5 a small group rating rules methodology that allows
6 for a variation that is less than the variation pro-
7 vided for under subsection (a)(1) (concerning min-
8 imum standards for premium variation), shall be
9 deemed to be an adopting State if the State complies
10 with the transitional small group rating rules as pro-
11 mulgated by the Secretary pursuant to paragraph
12 (1).

13 "(3) TRANSITIONING OF OLD BUSINESS.—

14 "(A) IN GENERAL.—In developing the
15 transitional small group rating rules under
16 paragraph (1), the Secretary shall, after con-
17 sultation with the National Association of In-
18 surance Commissioners and representatives of
19 insurers operating in the small group health in-
20 surance market in non-adopting States, promul-
21 gate special transition standards with respect to
22 independent rating classes for old and new busi-
23 ness, to the extent reasonably necessary to pro-
24 tect health insurance consumers and to ensure

1 a stable and fair transition for old and new
2 market entrants.
3 "(B) PERIOD FOR OPERATION OF INDE-
4 PENDENT RATING CLASSES.—In developing the
5 special transition standards pursuant to sub-
6 paragraph (A), the Secretary shall permit a
7 carrier in a non-adopting State, at its option, to
8 maintain independent rating classes for old and
9 new business for a period of up to 5 years, with
10 the commencement of such 5-year period to
11 begin at such time, but not later than the date
12 that is 3 years after the date of enactment of
13 this title, as the carrier offers a book of busi-
14 ness meeting the minimum standards for pre-
15 mium variation provided for in subsection
16 (a)(1) or the transitional small group rating
17 rules under paragraph (1).
18 "(4) OTHER TRANSITIONAL AUTHORITY.—In
19 developing the transitional small group rating rules
20 under paragraph (1), the Secretary shall provide for
21 the application of the transitional small group rating
22 rules in transition States as the Secretary may de-
23 termine necessary for a an effective transition.
24 "(c) MARKET RE-ENTRY.—

1 "(1) IN GENERAL.—Notwithstanding any other
2 provision of law, a health insurance issuer that has
3 voluntarily withdrawn from providing coverage in the
4 small group market prior to the date of enactment
5 of this title shall not be excluded from re-entering
6 such market on a date that is more than 180 days
7 after such date of enactment.

8 "(2) TERMINATION.—The provision of this sub-
9 section shall terminate on the date that is 24
10 months after the date of enactment of this title.

11 **"SEC. 3113. APPLICATION AND PREEMPTION.**

12 "(a) SUPERSEDING OF STATE LAW.—

13 "(1) IN GENERAL.—This part shall supersede
14 any and all State laws of a non-adopting State inso-
15 far as such State laws (whether enacted prior to or
16 after the date of enactment of this subtitle) relate to
17 rating in the small group insurance market as ap-
18 plied to an eligible insurer, or small group health in-
19 surance coverage issued by an eligible insurer, in-
20 cluding with respect to coverage issued to a small
21 employer through a small business health plan, in a
22 State.

23 "(2) NONADOPTING STATES.—This part shall
24 supersede any and all State laws of a nonadopting
25 State insofar as such State laws (whether enacted

1 prior to or after the date of enactment of this sub-
2 title)—
3 "(A) prohibit an eligible insurer from of-
4 fering, marketing, or implementing small group
5 health insurance coverage consistent with the
6 Model Small Group Rating Rules or transitional
7 model small group rating rules; or
8 "(B) have the effect of retaliating against
9 or otherwise punishing in any respect an eligible
10 insurer for offering, marketing, or imple-
11 menting small group health insurance coverage
12 consistent with the Model Small Group Rating
13 Rules or transitional model small group rating
14 rules.
15 "(b) SAVINGS CLAUSE AND CONSTRUCTION.—
16 "(1) NONAPPLICATION TO ADOPTING STATES.—
17 Subsection (a) shall not apply with respect to adopt-
18 ing states.
19 "(2) NONAPPLICATION TO CERTAIN INSUR-
20 ERS.—Subsection (a) shall not apply with respect to
21 insurers that do not qualify as eligible insurers that
22 offer small group health insurance coverage in a
23 nonadopting State.
24 "(3) NONAPPLICATION WHERE OBTAINING RE-
25 LIEF UNDER STATE LAW.—Subsection (a)(1) shall

1 not supercede any State law in a nonadopting State
2 to the extent necessary to permit individuals or the
3 insurance department of the State (or other State
4 agency) to obtain relief under State law to require
5 an eligible insurer to comply with the Model Small
6 Group Rating Rules or transitional model small
7 group rating rules.

8 ‘‘(4) NO EFFECT ON PREEMPTION.—In no case
9 shall this part be construed to limit or affect in any
10 manner the preemptive scope of sections 502 and
11 514 of the Employee Retirement Income Security
12 Act of 1974. In no case shall this part be construed
13 to create any cause of action under Federal or State
14 law or enlarge or affect any remedy available under
15 the Employee Retirement Income Security Act of
16 1974.

17 ‘‘(5) PREEMPTION LIMITED TO RATING.—Sub-
18 section (a) shall not preempt any State law that
19 does not have a reference to or a connection with
20 State rating rules that would otherwise apply to eli-
21 gible insurers.

22 ‘‘(c) EFFECTIVE DATE.—This section shall apply, at
23 the election of the eligible insurer, beginning in the first
24 plan year or the first calendar year following the issuance
25 of the final rules by the Secretary under the Model Small

Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

"SEC. 3114. CIVIL ACTIONS AND JURISDICTION.

"(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

"(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 3113.

"(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

"(d) EXPEDITED REVIEW.—

"(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such

action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

"(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

"(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

"SEC. 3115. ONGOING REVIEW.

"Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Com-

1 missioners, shall prepare and submit to the appropriate
2 committees of Congress a report that assesses the effect
3 of the Model Small Group Rating Rules on access, cost,
4 and market functioning in the small group market. Such
5 report may, if the Secretary, in consultation with the Na-
6 tional Association of Insurance Commissioners, deter-
7 mines such is appropriate for improving access, costs, and
8 market functioning, contain legislative proposals for rec-
9 ommended modification to such Model Small Group Rat-
10 ing Rules.

11 **"PART II—AFFORDABLE PLANS**

12 **"SEC. 3121. DEFINITIONS.**

13 "In this part:

14 "(1) ADOPTING STATE.—The term 'adopting
15 State' means a State that has enacted a law pro-
16 viding that small group, individual, and large group
17 health insurers in such State may offer and sell
18 products in accordance with the List of Required
19 Benefits and the Terms of Application as provided
20 for in section 3122(b).

21 "(2) ELIGIBLE INSURER.—The term 'eligible
22 insurer' means a health insurance issuer that is li-
23 censed in a nonadopting State and that—

24 "(A) notifies the Secretary, not later than
25 30 days prior to the offering of coverage de-

1 scribed in this subparagraph, that the issuer in-
2 tends to offer health insurance coverage con-
3 sistent with the List of Required Benefits and
4 Terms of Application in a nonadopting State;

5 ''(B) notifies the insurance department of
6 a nonadopting State (or other applicable State
7 agency), not later than 30 days prior to the of-
8 fering of coverage described in this subpara-
9 graph, that the issuer intends to offer health in-
10 surance coverage in that State consistent with
11 the List of Required Benefits and Terms of Ap-
12 plication, and provides with such notice a copy
13 of any insurance policy that it intends to offer
14 in the State, its most recent annual and quar-
15 terly financial reports, and any other informa-
16 tion required to be filed with the insurance de-
17 partment of the State (or other State agency)
18 by the Secretary in regulations; and

19 ''(C) includes in the terms of the health in-
20 surance coverage offered in nonadopting States
21 (including in the terms of any individual certifi-
22 cates that may be offered to individuals in con-
23 nection with such group health coverage) and
24 filed with the State pursuant to subparagraph
25 (B), a description in the insurer's contract of

1 the List of Required Benefits and a description
2 of the Terms of Application, including a de-
3 scription of the benefits to be provided, and
4 that adherence to such standards is included as
5 a term of such contract.

6 ''(3) HEALTH INSURANCE COVERAGE.—The
7 term 'health insurance coverage' means any coverage
8 issued in the small group, individual, or large group
9 health insurance markets, including with respect to
10 small business health plans, except that such term
11 shall not include excepted benefits (as defined in sec-
12 tion 2791(c)).

13 ''(4) LIST OF REQUIRED BENEFITS.—The term
14 'List of Required Benefits' means the List issued
15 under section 3122(a).

16 ''(5) NONADOPTING STATE.—The term 'non-
17 adopting State' means a State that is not an adopt-
18 ing State.

19 ''(6) STATE LAW.—The term 'State law' means
20 all laws, decisions, rules, regulations, or other State
21 actions (including actions by a State agency) having
22 the effect of law, of any State.

23 ''(7) STATE PROVIDER FREEDOM OF CHOICE
24 LAW.—The term 'State Provider Freedom of Choice
25 Law' means a State law requiring that a health in-

1 surance issuer, with respect to health insurance cov-
2 erage, not discriminate with respect to participation,
3 reimbursement, or indemnification as to any pro-
4 vider who is acting within the scope of the provider's
5 license or certification under applicable State law.
6 ''(8) TERMS OF APPLICATION.—The term
7 'Terms of Application' means terms provided under
8 section 3122(a).

9 **''SEC. 3122. OFFERING AFFORDABLE PLANS.**

10 ''(a) LIST OF REQUIRED BENEFITS.—Not later than
11 3 months after the date of enactment of this title, the Sec-
12 retary, in consultation with the National Association of In-
13 surance Commissioners, shall issue by interim final rule
14 a list (to be known as the 'List of Required Benefits') of
15 covered benefits, services, or categories of providers that
16 are required to be provided by health insurance issuers,
17 in each of the small group, individual, and large group
18 markets, in at least 26 States as a result of the application
19 of State covered benefit, service, and category of provider
20 mandate laws. With respect to plans sold to or through
21 small business health plans, the List of Required Benefits
22 applicable to the small group market shall apply.
23 ''(b) TERMS OF APPLICATION.—
24 ''(1) STATE WITH MANDATES.—With respect to
25 a State that has a covered benefit, service, or cat-

1 egory of provider mandate in effect that is covered
2 under the List of Required Benefits under sub-
3 section (a), such State mandate shall, subject to
4 paragraph (3) (concerning uniform application),
5 apply to a coverage plan or plan in, as applicable,
6 the small group, individual, or large group market or
7 through a small business health plan in such State.
8 "(2) STATES WITHOUT MANDATES.—With re-
9 spect to a State that does not have a covered ben-
10 efit, service, or category of provider mandate in ef-
11 fect that is covered under the List of Required Ben-
12 efits under subsection (a), such mandate shall not
13 apply, as applicable, to a coverage plan or plan in
14 the small group, individual, or large group market or
15 through a small business health plan in such State.
16 "(3) UNIFORM APPLICATION OF LAWS.—
17 "(A) IN GENERAL.—With respect to a
18 State described in paragraph (1), in applying a
19 covered benefit, service, or category of provider
20 mandate that is on the List of Required Bene-
21 fits under subsection (a) the State shall permit
22 a coverage plan or plan offered in the small
23 group, individual, or large group market or
24 through a small business health plan in such
25 State to apply such benefit, service, or category

1 of provider coverage in a manner consistent
2 with the manner in which such coverage is ap-
3 plied under one of the three most heavily sub-
4 scribed national health plans offered under the
5 Federal Employee Health Benefits Program
6 under chapter 89 of title 5, United States Code
7 (as determined by the Secretary in consultation
8 with the Director of the Office of Personnel
9 Management), and consistent with the Publica-
10 tion of Benefit Applications under subsection
11 (c). In the event a covered benefit, service, or
12 category of provider appearing in the List of
13 Required Benefits is not offered in one of the
14 three most heavily subscribed national health
15 plans offered under the Federal Employees
16 Health Benefits Program, such covered benefit,
17 service, or category of provider requirement
18 shall be applied in a manner consistent with the
19 manner in which such coverage is offered in the
20 remaining most heavily subscribed plan of the
21 remaining Federal Employees Health Benefits
22 Program plans, as determined by the Secretary,
23 in consultation with the Director of the Office
24 of Personnel Management.

1 "(B) EXCEPTION REGARDING STATE PRO-
2 VIDER FREEDOM OF CHOICE LAWS.—Notwith-
3 standing subparagraph (A), in the event a cat-
4 egory of provider mandate is included in the
5 List of Covered Benefits, any State Provider
6 Freedom of Choice Law (as defined in section
7 3121(7)) that is in effect in any State in which
8 such category of provider mandate is in effect
9 shall not be preempted, with respect to that cat-
10 egory of provider, by this part.

11 "(c) PUBLICATION OF BENEFIT APPLICATIONS.—
12 Not later than 3 months after the date of enactment of
13 this title, and on the first day of every calendar year there-
14 after, the Secretary, in consultation with the Director of
15 the Office of Personnel Management, shall publish in the
16 Federal Register a description of such covered benefits,
17 services, and categories of providers covered in that cal-
18 endar year by each of the three most heavily subscribed
19 nationally available Federal Employee Health Benefits
20 Plan options which are also included on the List of Re-
21 quired Benefits.

22 "(d) EFFECTIVE DATES.—

23 "(1) SMALL BUSINESS HEALTH PLANS.—With
24 respect to health insurance provided to participating
25 employers of small business health plans, the re-

1 quirements of this part (concerning lower cost plans)
2 shall apply beginning on the date that is 12 months
3 after the date of enactment of this title.

4 "(2) NON-ASSOCIATION COVERAGE.—With re-
5 spect to health insurance provided to groups or indi-
6 viduals other than participating employers of small
7 business health plans, the requirements of this part
8 shall apply beginning on the date that is 15 months
9 after the date of enactment of this title.

10 "(e) UPDATING OF LIST OF REQUIRED BENEFITS.—
11 Not later than 2 years after the date on which the list
12 of required benefits is issued under subsection (a), and
13 every 2 years thereafter, the Secretary, in consultation
14 with the National Association of Insurance Commis-
15 sioners, shall update the list based on changes in the laws
16 and regulations of the States. The Secretary shall issue
17 the updated list by regulation, and such updated list shall
18 be effective upon the first plan year following the issuance
19 of such regulation.

20 **"SEC. 3123. APPLICATION AND PREEMPTION.**

21 "(a) SUPERCEDING OF STATE LAW.—

22 "(1) IN GENERAL.—This part shall supersede
23 any and all State laws insofar as such laws relate to
24 mandates relating to covered benefits, services, or
25 categories of provider in the health insurance market

1 as applied to an eligible insurer, or health insurance
2 coverage issued by an eligible insurer, including with
3 respect to coverage issued to a small business health
4 plan, in a nonadopting State.

5 ''(2) NONADOPTING STATES.—This part shall
6 supersede any and all State laws of a nonadopting
7 State (whether enacted prior to or after the date of
8 enactment of this title) insofar as such laws—

9 ''(A) prohibit an eligible insurer from of-
10 fering, marketing, or implementing health in-
11 surance coverage consistent with the Benefit
12 Choice Standards, as provided for in section
13 3122(a); or

14 ''(B) have the effect of retaliating against
15 or otherwise punishing in any respect an eligible
16 insurer for offering, marketing, or imple-
17 menting health insurance coverage consistent
18 with the Benefit Choice Standards.

19 ''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

20 ''(1) NONAPPLICATION TO ADOPTING STATES.—
21 Subsection (a) shall not apply with respect to adopt-
22 ing States.

23 ''(2) NONAPPLICATION TO CERTAIN INSUR-
24 ERS.—Subsection (a) shall not apply with respect to
25 insurers that do not qualify as eligible insurers who

1 offer health insurance coverage in a nonadopting
2 State.
3 "(3) NONAPPLICATION WHERE OBTAINING RE-
4 LIEF UNDER STATE LAW.—Subsection (a)(1) shall
5 not supercede any State law of a nonadopting State
6 to the extent necessary to permit individuals or the
7 insurance department of the State (or other State
8 agency) to obtain relief under State law to require
9 an eligible insurer to comply with the Benefit Choice
10 Standards.
11 "(4) NO EFFECT ON PREEMPTION.—In no case
12 shall this part be construed to limit or affect in any
13 manner the preemptive scope of sections 502 and
14 514 of the Employee Retirement Income Security
15 Act of 1974. In no case shall this part be construed
16 to create any cause of action under Federal or State
17 law or enlarge or affect any remedy available under
18 the Employee Retirement Income Security Act of
19 1974.
20 "(5) PREEMPTION LIMITED TO BENEFITS.—
21 Subsection (a) shall not preempt any State law that
22 does not have a reference to or a connection with
23 State mandates regarding covered benefits, services,
24 or categories of providers that would otherwise apply
25 to eligible insurers.

1 **"SEC. 3124. CIVIL ACTIONS AND JURISDICTION.**

2 "(a) IN GENERAL.—The courts of the United States
3 shall have exclusive jurisdiction over civil actions involving
4 the interpretation of this part.

5 "(b) ACTIONS.—An eligible insurer may bring an ac-
6 tion in the district courts of the United States for injunc-
7 tive or other equitable relief against any officials or agents
8 of a nonadopting State in connection with any conduct or
9 action, or proposed conduct or action, by such officials or
10 agents which violates, or which would if undertaken vio-
11 late, section 3123.

12 "(c) DIRECT FILING IN COURT OF APPEALS.—At the
13 election of the eligible insurer, an action may be brought
14 under subsection (b) directly in the United States Court
15 of Appeals for the circuit in which the nonadopting State
16 is located by the filing of a petition for review in such
17 Court.

18 "(d) EXPEDITED REVIEW.—

19 "(1) DISTRICT COURT.—In the case of an ac-
20 tion brought in a district court of the United States
21 under subsection (b), such court shall complete such
22 action, including the issuance of a judgment, prior
23 to the end of the 120-day period beginning on the
24 date on which such action is filed, unless all parties
25 to such proceeding agree to an extension of such pe-
26 riod.

1 "(2) COURT OF APPEALS.—In the case of an
2 action brought directly in a United States Court of
3 Appeal under subsection (c), or in the case of an ap-
4 peal of an action brought in a district court under
5 subsection (b), such Court shall complete all action
6 on the petition, including the issuance of a judg-
7 ment, prior to the end of the 60-day period begin-
8 ning on the date on which such petition is filed with
9 the Court, unless all parties to such proceeding
10 agree to an extension of such period.

11 "(e) STANDARD OF REVIEW.—A court in an action
12 filed under this section, shall render a judgment based on
13 a review of the merits of all questions presented in such
14 action and shall not defer to any conduct or action, or
15 proposed conduct or action, of a nonadopting State.

16 **"SEC. 3125. RULES OF CONSTRUCTION.**

17 "(a) IN GENERAL.—Notwithstanding any other pro-
18 vision of Federal or State law, a health insurance issuer
19 in an adopting State or an eligible insurer in a non-adopt-
20 ing State may amend its existing policies to be consistent
21 with the terms of this subtitle (concerning rating and ben-
22 efits).

23 "(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this
24 subtitle shall be construed to create any mandates for cov-
25 erage of benefits for HSA-qualified health plans that

would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS

SEC. 211. EXTENDING COVERAGE OF DEPENDENTS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 714 the following new section:

''SEC. 715. EXTENDING COVERAGE OF DEPENDENTS.

''(a) IN GENERAL.—In the case of a group health plan, or health insurance coverage offered in connection with a group health plan, that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan or coverage shall continue to treat the individual as a dependent child without regard to the individual's age until the individual turns 26 years of age.

''(b) CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan to provide benefits for dependent children as beneficiaries under the plan or to require a participant to elect coverage of dependent children.''.

1 (2) CLERICAL AMENDMENT.—The table of con-
2 tents of such Act is amended by inserting after the
3 item relating to section 714 the following new item:

"Sec. 715. Extending coverage of dependents.".

4 (b) PHSA.—Title XXVII of the Public Health Serv-
5 ice Act, as restored by section 2, is amended by inserting
6 after section 2707 the following new section:

7 **"SEC. 2708. EXTENDING COVERAGE OF DEPENDENTS.**

8 "(a) IN GENERAL.—In the case of a group health
9 plan, or health insurance coverage offered in connection
10 with a group health plan, that treats as a beneficiary
11 under the plan an individual who is a dependent child of
12 a participant or beneficiary under the plan, the plan or
13 coverage shall continue to treat the individual as a depend-
14 ent child without regard to the individual's age until the
15 individual turns 26 years of age.

16 "(b) CONSTRUCTION.—Nothing in this section shall
17 be construed as requiring a group health plan to provide
18 benefits for dependent children as beneficiaries under the
19 plan or to require a participant to elect coverage of de-
20 pendent children.".

21 (c) IRC.—

22 (1) IN GENERAL.—Subchapter B of chapter
23 100 of the Internal Revenue Code of 1986 is amend-
24 ed by adding at the end the following new section:

1 **“SEC. 9814. EXTENDING COVERAGE OF DEPENDENTS.**

2 ‘‘(a) IN GENERAL.—In the case of a group health
3 plan that treats as a beneficiary under the plan an indi-
4 vidual who is a dependent child of a participant or bene-
5 ficiary under the plan, the plan shall continue to treat the
6 individual as a dependent child without regard to the indi-
7 vidual's age until the individual turns 26 years of age.

8 ‘‘(b) CONSTRUCTION.—Nothing in this section shall
9 be construed as requiring a group health plan to provide
10 coverage for dependent children as beneficiaries under the
11 plan or to require a participant to elect coverage of de-
12 pendent children.''.

13 (2) CLERICAL AMENDMENT.—The table of sec-
14 tions in such subchapter is amended by adding at
15 the end the following new item:

‘‘Sec. 9814. Extending coverage of dependents.''.

16 (d) EFFECTIVE DATE.—The amendments made by
17 subsections (a), (b), and (c) shall apply to group health
18 plans for plan years beginning more than 3 months after
19 the date of the enactment of this Act and shall apply to
20 individuals who are dependent children under a group
21 health plan, or health insurance coverage offered in con-
22 nection with such a plan, on or after such date.

23 (e) ADULT DEPENDENTS.—

24 (1) EXCLUSION OF AMOUNTS EXPENDED FOR
25 MEDICAL CARE.—The first sentence of section

1 105(b) of the Internal Revenue Code of 1986 (relat-
2 ing to amounts expended for medical care) is amend-
3 ed—
4 (A) by striking "and his dependents" and
5 inserting "his dependents"; and
6 (B) by inserting before the period the fol-
7 lowing: ", and any child (as defined in section
8 152(f)(1)) of the taxpayer who as of the end of
9 the taxable year has not attained age 27".
10 (2) SELF-EMPLOYED HEALTH INSURANCE DE-
11 DUCTION.—Section 162(l)(1) of such Code is
12 amended to read as follows:
13 "(1) ALLOWANCE OF DEDUCTION.—In the case
14 of a taxpayer who is an employee within the mean-
15 ing of section 401(c)(1), there shall be allowed as a
16 deduction under this section an amount equal to the
17 amount paid during the taxable year for insurance
18 which constitutes medical care for
19 "(A) the taxpayer,
20 "(B) the taxpayer's spouse,
21 "(C) the taxpayer's dependents, and
22 "(D) any child (as defined in section
23 152(f)(1)) of the taxpayer who as of the end of
24 the taxable year has not attained age 27.".

1 (3) COVERAGE UNDER SELF-EMPLOYED DEDUC-
2 TION.—Section 162(l)(2)(B) of such Code is amend-
3 ed by inserting '', or any dependent, or individual
4 described in subparagraph (D) of paragraph (1)
5 with respect to,'' after ''spouse of''.

6 (4) SICK AND ACCIDENT BENEFITS PROVIDED
7 TO MEMBERS OF A VOLUNTARY EMPLOYEES' BENE-
8 FICIARY ASSOCIATION AND THEIR DEPENDENTS.—
9 Section 501(c)(9) of such Code is amended by add-
10 ing at the end the following new sentence: ''For pur-
11 poses of providing for the payment of sick and acci-
12 dent benefits to members of such an association and
13 their dependents, the term 'dependent' shall include
14 any individual who is a child (as defined in section
15 152(f)(1)) of a member who as of the end of the cal-
16 endar year has not attained age 27.''.

17 (5) MEDICAL AND OTHER BENEFITS FOR RE-
18 TIRED EMPLOYEES.—Section 401(h) of such Code is
19 amended by adding at the end the following: ''For
20 purposes of this subsection, the term 'dependent'
21 shall include any individual who is a child (as de-
22 fined in section 152(f)(1)) of a retired employee who
23 as of the end of the calendar year has not attained
24 age 27.''.

1 **SEC. 212. PROHIBITING PREEXISTING CONDITION EXCLU-**
2 **SIONS FOR ENROLLEES UNDER AGE 19.**

3 (a) PHSA.—Section 2701(a) of the Public Health
4 Service Act (42 U.S.C. 300gg(a)), as restored by section
5 2, is amended—

6 (1) in the matter preceding paragraph (1), by
7 inserting "and the last sentence of this subsection"
8 after "subsection (d)"; and

9 (2) by adding at the end the following new sen-
10 tence:

11 "In the case of a participant or beneficiary who is under
12 19 years of age, a group health plan and a health insur-
13 ance issuer offering group or individual health insurance
14 coverage may not impose any preexisting condition exclu-
15 sion with respect to such plan or coverage.".

16 (b) ERISA.—Section 701(a) of the Employee Retire-
17 ment Income Security Act of 1974, as restored by section
18 2, is amended—

19 (1) in the matter preceding paragraph (1), by
20 inserting "and the last sentence of this subsection"
21 after "subsection (d)"; and

22 (2) by adding at the end the following new sen-
23 tence:

24 "In the case of a participant or beneficiary who is under
25 19 years of age, a group health plan and a health insur-
26 ance issuer offering group or individual health insurance

1 coverage may not impose any preexisting condition exclu-
2 sion with respect to such plan or coverage.''.
3 (c) IRC.—Section 9801 of the Internal Revenue Code
4 of 1986, as restored by section 2, is amended—
5 (1) in the matter preceding paragraph (1), by
6 inserting ''and the last sentence of this subsection''
7 after ''subsection (d)''; and
8 (2) by adding at the end the following new sen-
9 tence:
10 ''In the case of a participant or beneficiary who is under
11 19 years of age, a group health plan may not impose any
12 preexisting condition exclusion with respect to such plan.''.
13 **SEC. 213. HEALTH PLAN FINDERS.**
14 (a) STATE PLAN FINDERS.—Not later than 12
15 months after the date of the enactment of this Act, each
16 State may contract with a private entity to develop and
17 operate a plan finder website (referred to in this section
18 as a ''State plan finder'') which shall provide information
19 to individuals in such State on plans of health insurance
20 coverage that are available to individuals in such State (in
21 this section referred to as a ''health insurance plan'') .
22 Such State may not operate a plan finder itself.
23 (b) MULTI-STATE PLAN FINDERS.—
24 (1) IN GENERAL.—A private entity may operate
25 a multi-State finder that operates under this section

1 in the States involved in the same manner as a State
2 plan finder would operate in a single State.
3 (2) SHARING OF INFORMATION.—States shall
4 regulate the manner in which data is shared between
5 plan finders to ensure consistency and accuracy in
6 the information about health insurance plans con-
7 tained in such finders.
8 (c) REQUIREMENTS FOR PLAN FINDERS.—Each plan
9 finder shall meet the following requirements:
10 (1) The plan finder shall ensure that each
11 health insurance plan in the plan finder meets the
12 requirements for such plans under subsection (d).
13 (2) The plan finder shall present complete in-
14 formation on the costs and benefits of health insur-
15 ance plans (including information on monthly pre-
16 mium, copayments, and deductibles) in a uniform
17 manner that—
18 (A) uses the standard definitions developed
19 under paragraph (3); and
20 (B) is designed to allow consumers to eas-
21 ily compare such plans.
22 (3) The plan finder shall be available on the
23 Internet and accessible to all individuals in the State
24 or, in the case of a multi-State plan finder, in all
25 States covered by the multi-State plan finder.

1 (4) The plan finder shall allow consumers to
2 search and sort data on the health insurance plans
3 in the plan finder on criteria such as coverage of
4 specific benefits (such as coverage of disease man-
5 agement services or pediatric care services), as well
6 as data available on quality.

7 (5) The plan finder shall meet all relevant State
8 laws and regulations, including laws and regulations
9 related to the marketing of insurance products. In
10 the case of a multi-State plan finder, the finder shall
11 meet such laws and regulations for all of the States
12 involved.

13 (6) The plan finder shall meet solvency, finan-
14 cial, and privacy requirements established by the
15 State or States in which the plan finder operates or
16 the Secretary for multi-State finders.

17 (7) The plan finder and the employees of the
18 plan finder shall be appropriately licensed in the
19 State or States in which the plan finder operates, if
20 such licensure is required by such State or States.

21 (8) Notwithstanding subsection (f)(1), the plan
22 finder shall assist individuals who are eligible for the
23 Medicaid program under title XIX of the Social Se-
24 curity Act or State Children's Health Insurance Pro-
25 gram under title XXI of such Act by including infor-

1 mation on Medicaid options, eligibility, and how to
2 enroll.

3 (d) REQUIREMENTS FOR PLANS PARTICIPATING IN
4 A PLAN FINDER.—

5 (1) IN GENERAL.—Each State shall ensure that
6 health insurance plans participating in the State
7 plan finder or in a multi-State plan finder meet the
8 requirements of paragraph (2) (relating to adequacy
9 of insurance coverage, consumer protection, and fi-
10 nancial strength).

11 (2) SPECIFIC REQUIREMENTS.—In order to
12 participate in a plan finder, a health insurance plan
13 must meet all of the following requirements, as de-
14 termined by each State in which such plan operates:

15 (A) The health insurance plan shall be ac-
16 tuarially sound.

17 (B) The health insurance plan may not
18 have a history of abusive policy rescissions.

19 (C) The health insurance plan shall meet
20 financial and solvency requirements.

21 (D) The health insurance plan shall dis-
22 close—

23 (i) all financial arrangements involv-
24 ing the sale and purchase of health insur-

1 ance, such as the payment of fees and
2 commissions; and
3 (ii) such arrangements may not be
4 abusive.
5 (E) The health insurance plan shall main-
6 tain electronic health records that comply with
7 the requirements of the American Recovery and
8 Reinvestment Act of 2009 (Public Law 111–5)
9 related to electronic health records.
10 (F) The health insurance plan shall make
11 available to plan enrollees via the finder, wheth-
12 er by information provided to the finder or by
13 a website link directing the enrollee from the
14 finder to the health insurance plan website,
15 data that includes the price and cost to the in-
16 dividual of services offered by a provider ac-
17 cording to the terms and conditions of the
18 health plan. Data described in this paragraph is
19 not made public by the finder, only made avail-
20 able to the individual once enrolled in the
21 health plan.
22 (e) PROHIBITIONS.—
23 (1) DIRECT ENROLLMENT.—The State plan
24 finder may not directly enroll individuals in health
25 insurance plans.

1 (2) CONFLICTS OF INTEREST.—
2 (A) COMPANIES.—A health insurance
3 issuer offering a health insurance plan through
4 a plan finder may not—
5 (i) be the private entity developing
6 and maintaining a plan finder under sub-
7 sections (a) and (b); or
8 (ii) have an ownership interest in such
9 private entity or in the plan finder.
10 (B) INDIVIDUALS.—An individual em-
11 ployed by a health insurance issuer offering a
12 health insurance plan through a plan finder
13 may not serve as a director or officer for—
14 (i) the private entity developing and
15 maintaining a plan finder under sub-
16 sections (a) and (b); or
17 (ii) the plan finder.
18 (f) CONSTRUCTION.—Nothing in this section shall be
19 construed to allow the Secretary authority to regulate ben-
20 efit packages or to prohibit health insurance brokers and
21 agents from—
22 (1) utilizing the plan finder for any purpose; or
23 (2) marketing or offering health insurance
24 products.

(g) PLAN FINDER DEFINED.—For purposes of this section, the term ''plan finder'' means a State plan finder under subsection (a) or a multi-State plan finder under subsection (b).

(h) STATE DEFINED.—In this section, the term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

TITLE III—EXPANDING CHOICES BY ALLOWING AMERICANS TO BUY HEALTH CARE COVERAGE ACROSS STATE LINES

SEC. 221. INTERSTATE PURCHASING OF HEALTH INSURANCE.

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

''PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

''SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State

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

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

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

1 "(4) INDIVIDUAL HEALTH INSURANCE COV-
2 ERAGE.—The term 'individual health insurance cov-
3 erage' means health insurance coverage offered in
4 the individual market, as defined in section
5 2791(e)(1).
6 "(5) APPLICABLE STATE AUTHORITY.—The
7 term 'applicable State authority' means, with respect
8 to a health insurance issuer in a State, the State in-
9 surance commissioner or official or officials des-
10 ignated by the State to enforce the requirements of
11 this title for the State with respect to the issuer.
12 "(6) HAZARDOUS FINANCIAL CONDITION.—The
13 term 'hazardous financial condition' means that,
14 based on its present or reasonably anticipated finan-
15 cial condition, a health insurance issuer is unlikely
16 to be able—
17 "(A) to meet obligations to policyholders
18 with respect to known claims and reasonably
19 anticipated claims; or
20 "(B) to pay other obligations in the normal
21 course of business.
22 "(7) COVERED LAWS.—
23 "(A) IN GENERAL.—The term 'covered
24 laws' means the laws, rules, regulations, agree-

1 ments, and orders governing the insurance busi-
2 ness pertaining to—
3 "(i) individual health insurance cov-
4 erage issued by a health insurance issuer;
5 "(ii) the offer, sale, rating (including
6 medical underwriting), renewal, and
7 issuance of individual health insurance cov-
8 erage to an individual;
9 "(iii) the provision to an individual in
10 relation to individual health insurance cov-
11 erage of health care and insurance related
12 services;
13 "(iv) the provision to an individual in
14 relation to individual health insurance cov-
15 erage of management, operations, and in-
16 vestment activities of a health insurance
17 issuer; and
18 "(v) the provision to an individual in
19 relation to individual health insurance cov-
20 erage of loss control and claims adminis-
21 tration for a health insurance issuer with
22 respect to liability for which the issuer pro-
23 vides insurance.
24 "(B) EXCEPTION.—Such term does not in-
25 clude any law, rule, regulation, agreement, or

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

6 ''(8) STATE.—The term 'State' means the 50
7 States and includes the District of Columbia, Puerto
8 Rico, the Virgin Islands, Guam, American Samoa,
9 and the Northern Mariana Islands.

10 ''(9) UNFAIR CLAIMS SETTLEMENT PRAC-
11 TICES.—The term 'unfair claims settlement prac-
12 tices' means only the following practices:

13 ''(A) Knowingly misrepresenting to claim-
14 ants and insured individuals relevant facts or
15 policy provisions relating to coverage at issue.

16 ''(B) Failing to acknowledge with reason-
17 able promptness pertinent communications with
18 respect to claims arising under policies.

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

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

1 “(E) Refusing to pay claims without con-
2 ducting a reasonable investigation.
3 “(F) Failing to affirm or deny coverage of
4 claims within a reasonable period of time after
5 having completed an investigation related to
6 those claims.
7 “(G) A pattern or practice of compelling
8 insured individuals or their beneficiaries to in-
9 stitute suits to recover amounts due under its
10 policies by offering substantially less than the
11 amounts ultimately recovered in suits brought
12 by them.
13 “(H) A pattern or practice of attempting
14 to settle or settling claims for less than the
15 amount that a reasonable person would believe
16 the insured individual or his or her beneficiary
17 was entitled by reference to written or printed
18 advertising material accompanying or made
19 part of an application.
20 “(I) Attempting to settle or settling claims
21 on the basis of an application that was materi-
22 ally altered without notice to, or knowledge or
23 consent of, the insured.
24 “(J) Failing to provide forms necessary to
25 present claims within 15 calendar days of a re-

quests with reasonable explanations regarding their use.

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

"(10) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

"(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

"(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

"(ii) The rating of an insurance policy or reinsurance contract.

"(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

1 "(iv) Premiums paid on an insurance
2 policy or reinsurance contract.
3 "(v) Payments made in accordance
4 with the terms of an insurance policy or
5 reinsurance contract.
6 "(vi) A document filed with the com-
7 missioner or the chief insurance regulatory
8 official of another jurisdiction.
9 "(vii) The financial condition of an in-
10 surer or reinsurer.
11 "(viii) The formation, acquisition,
12 merger, reconsolidation, dissolution or
13 withdrawal from one or more lines of in-
14 surance or reinsurance in all or part of a
15 State by an insurer or reinsurer.
16 "(ix) The issuance of written evidence
17 of insurance.
18 "(x) The reinstatement of an insur-
19 ance policy.
20 "(B) Solicitation or acceptance of new or
21 renewal insurance risks on behalf of an insurer
22 reinsurer or other person engaged in the busi-
23 ness of insurance by a person who knows or
24 should know that the insurer or other person

1 responsible for the risk is insolvent at the time
2 of the transaction.
3 ‘‘(C) Transaction of the business of insur-
4 ance in violation of laws requiring a license, cer-
5 tificate of authority or other legal authority for
6 the transaction of the business of insurance.
7 ‘‘(D) Attempt to commit, aiding or abet-
8 ting in the commission of, or conspiracy to com-
9 mit the acts or omissions specified in this para-
10 graph.

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

12 ‘‘(a) IN GENERAL.—The covered laws of the primary
13 State shall apply to individual health insurance coverage
14 offered by a health insurance issuer in the primary State
15 and in any secondary State, but only if the coverage and
16 issuer comply with the conditions of this section with re-
17 spect to the offering of coverage in any secondary State.
18 ‘‘(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
19 ONDARY STATE.—Except as provided in this section, a
20 health insurance issuer with respect to its offer, sale, rat-
21 ing (including medical underwriting), renewal, and
22 issuance of individual health insurance coverage in any
23 secondary State is exempt from any covered laws of the
24 secondary State (and any rules, regulations, agreements,

or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

"(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

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

"(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

"(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

"(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

1 "(ii) any such examination is con-
2 ducted in accordance with the examiners'
3 handbook of the National Association of
4 Insurance Commissioners and is coordi-
5 nated to avoid unjustified duplication and
6 unjustified repetition;
7 "(D) to comply with a lawful order
8 issued—
9 "(i) in a delinquency proceeding com-
10 menced by the State insurance commis-
11 sioner if there has been a finding of finan-
12 cial impairment under subparagraph (C);
13 or
14 "(ii) in a voluntary dissolution pro-
15 ceeding;
16 "(E) to comply with an injunction issued
17 by a court of competent jurisdiction, upon a pe-
18 tition by the State insurance commissioner al-
19 leging that the issuer is in hazardous financial
20 condition;
21 "(F) to participate, on a nondiscriminatory
22 basis, in any insurance insolvency guaranty as-
23 sociation or similar association to which a
24 health insurance issuer in the State is required
25 to belong;

1 "(G) to comply with any State law regard-
2 ing fraud and abuse (as defined in section
3 2795(10)), except that if the State seeks an in-
4 junction regarding the conduct described in this
5 subparagraph, such injunction must be obtained
6 from a court of competent jurisdiction;
7 "(H) to comply with any State law regard-
8 ing unfair claims settlement practices (as de-
9 fined in section 2795(9)); or
10 "(I) to comply with the applicable require-
11 ments for independent review under section
12 2798 with respect to coverage offered in the
13 State;
14 "(2) require any individual health insurance
15 coverage issued by the issuer to be countersigned by
16 an insurance agent or broker residing in that Sec-
17 ondary State; or
18 "(3) otherwise discriminate against the issuer
19 issuing insurance in both the primary State and in
20 any secondary State.
21 "(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
22 health insurance issuer shall provide the following notice,
23 in 12-point bold type, in any insurance coverage offered
24 in a secondary State under this part by such a health in-
25 surance issuer and at renewal of the policy, with the 5

1 blank spaces therein being appropriately filled with the
2 name of the health insurance issuer, the name of primary
3 State, the name of the secondary State, the name of the
4 secondary State, and the name of the secondary State, re-
5 spectively, for the coverage concerned:

6 **THIS POLICY IS ISSUED BY ________ AND**
7 **IS GOVERNED BY THE LAWS AND REGULA-**
8 **TIONS OF THE STATE OF ________, AND IT**
9 **HAS MET ALL THE LAWS OF THAT STATE**
10 **AS DETERMINED BY THAT STATE'S DE-**
11 **PARTMENT OF INSURANCE. THIS POLICY**
12 **MAY BE LESS EXPENSIVE THAN OTHERS**
13 **BECAUSE IT IS NOT SUBJECT TO ALL OF**
14 **THE INSURANCE LAWS AND REGULATIONS**
15 **OF THE STATE OF ________, INCLUDING**
16 **COVERAGE OF SOME SERVICES OR BENE-**
17 **FITS MANDATED BY THE LAW OF THE**
18 **STATE OF ________. ADDITIONALLY, THIS**
19 **POLICY IS NOT SUBJECT TO ALL OF THE**
20 **CONSUMER PROTECTION LAWS OR RE-**
21 **STRICTIONS ON RATE CHANGES OF THE**
22 **STATE OF ________. AS WITH ALL INSUR-**
23 **ANCE PRODUCTS, BEFORE PURCHASING**
24 **THIS POLICY, YOU SHOULD CAREFULLY**
25 **REVIEW THE POLICY AND DETERMINE**

1 **WHAT HEALTH CARE SERVICES THE POL-**
2 **ICY COVERS AND WHAT BENEFITS IT PRO-**
3 **VIDES, INCLUDING ANY EXCLUSIONS, LIM-**
4 **ITATIONS, OR CONDITIONS FOR SUCH**
5 **SERVICES OR BENEFITS.**''.

6 ''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
7 AND PREMIUM INCREASES.—

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

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

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

23 ''(2) CONSTRUCTION.—Nothing in paragraph
24 (1) shall be construed to prohibit a health insurance
25 issuer—

1 ''(A) from terminating or discontinuing
2 coverage or a class of coverage in accordance
3 with subsections (b) and (c) of section 2742;
4 ''(B) from raising premium rates for all
5 policy holders within a class based on claims ex-
6 perience;
7 ''(C) from changing premiums or offering
8 discounted premiums to individuals who engage
9 in wellness activities at intervals prescribed by
10 the issuer, if such premium changes or incen-
11 tives—
12 ''(i) are disclosed to the consumer in
13 the insurance contract;
14 ''(ii) are based on specific wellness ac-
15 tivities that are not applicable to all indi-
16 viduals; and
17 ''(iii) are not obtainable by all individ-
18 uals to whom coverage is offered;
19 ''(D) from reinstating lapsed coverage; or
20 ''(E) from retroactively adjusting the rates
21 charged an insured individual if the initial rates
22 were set based on material misrepresentation by
23 the individual at the time of issue.
24 ''(e) PRIOR OFFERING OF POLICY IN PRIMARY
25 STATE.—A health insurance issuer may not offer for sale

individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

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

"(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

"(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

"(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which

1 shall include the name of its primary State and
2 its principal place of business);
3 ‘‘(B) written notice of any change in its
4 designation of its primary State; and
5 ‘‘(C) written notice from the issuer of the
6 issuer’s compliance with all the laws of the pri-
7 mary State; and
8 ‘‘(2) to the insurance commissioner of each sec-
9 ondary State in which it offers individual health in-
10 surance coverage, a copy of the issuer’s quarterly fi-
11 nancial statement submitted to the primary State,
12 which statement shall be certified by an independent
13 public accountant and contain a statement of opin-
14 ion on loss and loss adjustment expense reserves
15 made by—
16 ‘‘(A) a member of the American Academy
17 of Actuaries; or
18 ‘‘(B) a qualified loss reserve specialist.
19 ‘‘(h) POWER OF COURTS TO ENJOIN CONDUCT.—
20 Nothing in this section shall be construed to affect the
21 authority of any Federal or State court to enjoin—
22 ‘‘(1) the solicitation or sale of individual health
23 insurance coverage by a health insurance issuer to
24 any person or group who is not eligible for such in-
25 surance; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 "(2) LICENSURE AND EXPERTISE.—Each inde-
23 pendent medical reviewer shall be a physician
24 (allopathic or osteopathic) or health care profes-
25 sional who—

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

4 "(B) typically treats the condition, makes
5 the diagnosis, or provides the type of treatment
6 under review.

7 "(3) INDEPENDENCE.—

8 "(A) IN GENERAL.—Subject to subpara-
9 graph (B), each independent medical reviewer
10 in a case shall—

11 "(i) not be a related party (as defined
12 in paragraph (7));

13 "(ii) not have a material familial, fi-
14 nancial, or professional relationship with
15 such a party; and

16 "(iii) not otherwise have a conflict of
17 interest with such a party (as determined
18 under regulations).

19 "(B) EXCEPTION.—Nothing in subpara-
20 graph (A) shall be construed to—

21 "(i) prohibit an individual, solely on
22 the basis of affiliation with the issuer,
23 from serving as an independent medical re-
24 viewer if—

1 "(I) a non-affiliated individual is
2 not reasonably available;
3 "(II) the affiliated individual is
4 not involved in the provision of items
5 or services in the case under review;
6 "(III) the fact of such an affili-
7 ation is disclosed to the issuer and the
8 enrollee (or authorized representative)
9 and neither party objects; and
10 "(IV) the affiliated individual is
11 not an employee of the issuer and
12 does not provide services exclusively or
13 primarily to or on behalf of the issuer;
14 "(ii) prohibit an individual who has
15 staff privileges at the institution where the
16 treatment involved takes place from serv-
17 ing as an independent medical reviewer
18 merely on the basis of such affiliation if
19 the affiliation is disclosed to the issuer and
20 the enrollee (or authorized representative),
21 and neither party objects; or
22 "(iii) prohibit receipt of compensation
23 by an independent medical reviewer from
24 an entity if the compensation is provided
25 consistent with paragraph (6).

1 "(4) PRACTICING HEALTH CARE PROFESSIONAL
2 IN SAME FIELD.—
3 "(A) IN GENERAL.—In a case involving
4 treatment, or the provision of items or serv-
5 ices—
6 "(i) by a physician, a reviewer shall be
7 a practicing physician (allopathic or osteo-
8 pathic) of the same or similar specialty, as
9 a physician who, acting within the appro-
10 priate scope of practice within the State in
11 which the service is provided or rendered,
12 typically treats the condition, makes the
13 diagnosis, or provides the type of treat-
14 ment under review; or
15 "(ii) by a non-physician health care
16 professional, the reviewer, or at least 1
17 member of the review panel, shall be a
18 practicing non-physician health care pro-
19 fessional of the same or similar specialty
20 as the non-physician health care profes-
21 sional who, acting within the appropriate
22 scope of practice within the State in which
23 the service is provided or rendered, typi-
24 cally treats the condition, makes the diag-

1 nosis, or provides the type of treatment
2 under review.
3 "(B) PRACTICING DEFINED.—For pur-
4 poses of this paragraph, the term 'practicing'
5 means, with respect to an individual who is a
6 physician or other health care professional, that
7 the individual provides health care services to
8 individual patients on average at least 2 days
9 per week.
10 "(5) PEDIATRIC EXPERTISE.—In the case of an
11 external review relating to a child, a reviewer shall
12 have expertise under paragraph (2) in pediatrics.
13 "(6) LIMITATIONS ON REVIEWER COMPENSA-
14 TION.—Compensation provided by the issuer to an
15 independent medical reviewer in connection with a
16 review under this section shall—
17 "(A) not exceed a reasonable level; and
18 "(B) not be contingent on the decision ren-
19 dered by the reviewer.
20 "(7) RELATED PARTY DEFINED.—For purposes
21 of this section, the term 'related party' means, with
22 respect to a denial of a claim under a coverage relat-
23 ing to an enrollee, any of the following:
24 "(A) The issuer involved, or any fiduciary,
25 officer, director, or employee of the issuer.

1 “(B) The enrollee (or authorized representative).
3 “(C) The health care professional that provides the items or services involved in the denial.
6 “(D) The institution at which the items or services (or treatment) involved in the denial are provided.
9 “(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.
12 “(F) Any other party determined under any regulations to have a substantial interest in the denial involved.
15 “(8) DEFINITIONS.—For purposes of this subsection:
17 “(A) ENROLLEE.—The term ‘enrollee’ means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.
22 “(B) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ means an individual who is licensed, accredited, or certified under State law to provide specified health care

1 services and who is operating within the scope
2 of such licensure, accreditation, or certification.
3 **"SEC. 2799. ENFORCEMENT.**
4 "(a) IN GENERAL.—Subject to subsection (b), with
5 respect to specific individual health insurance coverage the
6 primary State for such coverage has sole jurisdiction to
7 enforce the primary State's covered laws in the primary
8 State and any secondary State.
9 "(b) SECONDARY STATE'S AUTHORITY.—Nothing in
10 subsection (a) shall be construed to affect the authority
11 of a secondary State to enforce its laws as set forth in
12 the exception specified in section 2796(b)(1).
13 "(c) COURT INTERPRETATION.—In reviewing action
14 initiated by the applicable secondary State authority, the
15 court of competent jurisdiction shall apply the covered
16 laws of the primary State.
17 "(d) NOTICE OF COMPLIANCE FAILURE.—In the case
18 of individual health insurance coverage offered in a sec-
19 ondary State that fails to comply with the covered laws
20 of the primary State, the applicable State authority of the
21 secondary State may notify the applicable State authority
22 of the primary State.".
23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall apply to individual health insurance

1 coverage offered, issued, or sold after the date that is one
2 year after the date of the enactment of this Act.
3 (c) GAO ONGOING STUDY AND REPORTS.—
4 (1) STUDY.—The Comptroller General of the
5 United States shall conduct an ongoing study con-
6 cerning the effect of the amendment made by sub-
7 section (a) on—
8 (A) the number of uninsured and under-in-
9 sured;
10 (B) the availability and cost of health in-
11 surance policies for individuals with preexisting
12 medical conditions;
13 (C) the availability and cost of health in-
14 surance policies generally;
15 (D) the elimination or reduction of dif-
16 ferent types of benefits under health insurance
17 policies offered in different States; and
18 (E) cases of fraud or abuse relating to
19 health insurance coverage offered under such
20 amendment and the resolution of such cases.
21 (2) ANNUAL REPORTS.—The Comptroller Gen-
22 eral shall submit to Congress an annual report, after
23 the end of each of the 5 years following the effective
24 date of the amendment made by subsection (a), on
25 the ongoing study conducted under paragraph (1).

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

SEC. 231. HSA FUNDS FOR PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986, as restored by section 2, is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'', and by adding at the end the following:

''(v) a high deductible health plan if—

''(I) such plan is not offered in connection with a group health plan,

''(II) no portion of any premium (within the meaning of applicable premium under section 4980B(f)(4)) for such plan is excludable from gross income under section 106, and

''(III) the account beneficiary demonstrates, using procedures deemed appropriate by the Secretary, that after payment of the premium for such insurance the balance in the health savings account is at least twice the minimum deductible in ef-

fect under subsection (c)(2)(A)(i) which is applicable to such plan.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for a high deductible health plan for periods beginning after December 31, 2011.

SEC. 232. REQUIRING GREATER COORDINATION BETWEEN HDHP ADMINISTRATORS AND HSA ACCOUNT ADMINISTRATORS SO THAT ENROLLEES CAN ENROLL IN BOTH AT THE SAME TIME.

The Secretary of the Treasury, through the issuance of regulations or other guidance, shall encourage administrators of health plans and trustees of health savings accounts to provide for simultaneous enrollment in high deductible health plans and setup of health savings accounts.

SEC. 233. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.

(a) IN GENERAL.—Subsection (d) of section 223 of the Internal Revenue Code of 1986, as restored by section 2, is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

1 "(4) CERTAIN MEDICAL EXPENSES INCURRED
2 BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS
3 QUALIFIED.—
4 "(A) IN GENERAL.—For purposes of para-
5 graph (2), an expense shall not fail to be treat-
6 ed as a qualified medical expense solely because
7 such expense was incurred before the establish-
8 ment of the health savings account if such ex-
9 pense was incurred during the 60-day period
10 beginning on the date on which the high de-
11 ductible health plan is first effective.
12 "(B) SPECIAL RULES.—For purposes of
13 subparagraph (A)—
14 "(i) an individual shall be treated as
15 an eligible individual for any portion of a
16 month for which the individual is described
17 in subsection (c)(1), determined without
18 regard to whether the individual is covered
19 under a high deductible health plan on the
20 1st day of such month, and
21 "(ii) the effective date of the health
22 savings account is deemed to be the date
23 on which the high deductible health plan is
24 first effective after the date of the enact-
25 ment of this paragraph.".

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply with respect to insurance pur-
3 chased after the date of the enactment of this Act in tax-
4 able years beginning after such date.

5 TITLE V—TAX–RELATED HEALTH 6 INCENTIVES

7 SEC. 241. SECA TAX DEDUCTION FOR HEALTH INSURANCE 8 COSTS.

9 (a) IN GENERAL.—Subsection (l) of section 162 of
10 the Internal Revenue Code of 1986 (relating to special
11 rules for health insurance costs of self-employed individ-
12 uals) is amended by striking paragraph (4) and by redes-
13 ignating paragraph (5) as paragraph (4).
14 (b) EFFECTIVE DATE.—The amendment made by
15 this section shall apply to taxable years beginning after
16 December 31, 2010.

17 SEC. 242. DEDUCTION FOR QUALIFIED HEALTH INSURANCE 18 COSTS OF INDIVIDUALS.

19 (a) IN GENERAL.—Part VII of subchapter B of chap-
20 ter 1 of the Internal Revenue Code of 1986 (relating to
21 additional itemized deductions for individuals) is amended
22 by redesignating section 224 as section 225 and by insert-
23 ing after section 223 the following new section:

1 **"SEC. 224. COSTS OF QUALIFIED HEALTH INSURANCE.**

2 ''(a) IN GENERAL.—In the case of an individual,
3 there shall be allowed as a deduction an amount equal to
4 the amount paid during the taxable year for coverage for
5 the taxpayer, his spouse, and dependents under qualified
6 health insurance.

7 ''(b) QUALIFIED HEALTH INSURANCE.—For pur-
8 poses of this section, the term 'qualified health insurance'
9 means insurance which constitutes medical care, other
10 than insurance substantially all of the coverage of which
11 is of excepted benefits described in section 9832(c).

12 ''(c) SPECIAL RULES.—

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

22 ''(2) DEDUCTION NOT ALLOWED FOR SELF-EM-
23 PLOYMENT TAX PURPOSES.—The deduction allow-
24 able by reason of this section shall not be taken into
25 account in determining an individual's net earnings

1 from self-employment (within the meaning of section
2 1402(a)) for purposes of chapter 2.''.
3 (b) DEDUCTION ALLOWED IN COMPUTING AD-
4 JUSTED GROSS INCOME.—Subsection (a) of section 62 of
5 such Code is amended by inserting before the last sentence
6 the following new paragraph:
7 ''(22) COSTS OF QUALIFIED HEALTH INSUR-
8 ANCE.—The deduction allowed by section 224.''.
9 (c) CLERICAL AMENDMENT.—The table of sections
10 for part VII of subchapter B of chapter 1 of such Code
11 is amended by redesignating the item relating to section
12 224 as an item relating to section 225 and inserting before
13 such item the following new item:

''Sec. 224. Costs of qualified health insurance.''.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to taxable years beginning after
16 December 31, 2010.

17 DIVISION C—ENACTING REAL 18 MEDICAL LIABILITY REFORM

19 SEC. 301. CAP ON NON-ECONOMIC DAMAGES AGAINST 20 HEALTH CARE PRACTITIONERS.

21 When an individual is injured or dies as the result
22 of health care, a person entitled to non-economic damages
23 may not recover, from the class of liable health care practi-
24 tioners (regardless of the theory of liability), more than
25 $250,000 such damages.

SEC. 302. CAP ON NON-ECONOMIC DAMAGES AGAINST HEALTH CARE INSTITUTIONS.

When an individual is injured or dies as the result of health care, a person entitled to non-economic damages may not recover—

(1) from any single liable health care institution (regardless of the theory of liability), more than $250,000 such damages; and

(2) from the class of liable health care institutions (regardless of the theory of liability), more than $500,000 such damages.

SEC. 303. CAP, IN WRONGFUL DEATH CASES, ON TOTAL DAMAGES AGAINST ANY SINGLE HEALTH CARE PRACTITIONER.

(a) IN GENERAL.—When an individual dies as the result of health care, a person entitled to damages may not recover, from any single liable health care practitioner (regardless of the theory of liability), more than $1,400,000 in total damages.

(b) TOTAL DAMAGES DEFINED.—In this section, the term ''total damages'' includes compensatory damages, punitive damages, statutory damages, and any other type of damages.

(c) ADJUSTMENT FOR INFLATION.—For each calendar year after the calendar year of the enactment of this Act, the dollar amount referred to in subsection (a)

1 shall be adjusted to reflect changes in the Consumer Price
2 Index of the Bureau of Labor Statistics of the Department
3 of Labor. The adjustment shall be based on the relation-
4 ship between—
5 (1) the Consumer Price Index data most re-
6 cently published as of January 1 of the calendar
7 year of the enactment of this Act; and
8 (2) the Consumer Price Index data most re-
9 cently published as of January 1 of the calendar
10 year concerned.
11 (d) APPLICABILITY OF ADJUSTMENT.—The dollar
12 amount that applies to a recovery is the dollar amount
13 for the calendar year during which the amount of the re-
14 covery is made final.

15 **SEC. 304. LIMITATION OF INSURER LIABILITY WHEN IN-**
16 **SURER REJECTS CERTAIN SETTLEMENT OF-**
17 **FERS.**

18 In a civil action, to the extent the civil action seeks
19 damages for the injury or death of an individual as the
20 result of health care, when the insurer of a health care
21 practitioner or health care institution rejects a reasonable
22 settlement offer within policy limits, the insurer is not, by
23 reason of that rejection, liable for damages in an amount
24 that exceeds the liability of the insured.

1 **SEC. 305. MANDATORY JURY INSTRUCTION ON CAP ON**
2 **DAMAGES.**

3 In a civil action tried to a jury, to the extent the civil
4 action seeks damages for the injury or death of an indi-
5 vidual as the result of health care, the court shall instruct
6 the jury that the jury is not to consider whether, or to
7 what extent, a limitation on damages applies.

8 **SEC. 306. DETERMINATION OF NEGLIGENCE; MANDATORY**
9 **JURY INSTRUCTION.**

10 (a) IN GENERAL.—When an individual is injured or
11 dies as the result of health care, liability for negligence
12 may not be based solely on a bad result.

13 (b) MANDATORY JURY INSTRUCTION.—In a civil ac-
14 tion tried to a jury, to the extent the civil action seeks
15 damages for the injury or death of an individual as the
16 result of health care and alleges liability for negligence,
17 the court shall instruct the jury as provided in subsection
18 (a).

19 **SEC. 307. EXPERT REPORTS REQUIRED TO BE SERVED IN**
20 **CIVIL ACTIONS.**

21 (a) SERVICE REQUIRED.—To the extent a pleading
22 filed in a civil action seeks damages against a health care
23 practitioner for the injury or death of an individual as the
24 result of health care, the party filing the pleading shall,
25 not later than 120 days after the date on which the plead-

1 ing was filed, serve on each party against whom such dam-
2 ages are sought a qualified expert report.

3 (b) QUALIFIED EXPERT REPORT.—As used in sub-
4 section (a), a qualified expert report is a written report
5 of a qualified health care expert that—

6 (1) includes a curriculum vitae for that expert;
7 and

8 (2) sets forth a summary of the expert opinion
9 of that expert as to—

10 (A) the standard of care applicable to that
11 practitioner;

12 (B) how that practitioner failed to meet
13 that standard of care; and

14 (C) the causal relationship between that
15 failure and the injury or death of the individual.

16 (c) MOTION TO ENFORCE.—A party not served as
17 required by subsection (a) may move the court to enforce
18 that subsection. On such a motion, the court—

19 (1) shall dismiss, with prejudice, the pleading
20 as it relates to that party; and

21 (2) shall award to that party the attorney fees
22 reasonably incurred by that party to respond to that
23 pleading.

24 (d) USE OF EXPERT REPORT.—

(1) IN GENERAL.—Except as otherwise provided in this section, a qualified expert report served under subsection (a) may not, in that civil action—

(A) be offered by any party as evidence;

(B) be used by any party in discovery or any other pretrial proceeding; or

(C) be referred to by any party at trial.

(2) VIOLATIONS.—

(A) BY OTHER PARTY.—If paragraph (1) is violated by a party other than the party who served the report, the court shall, on motion of any party or on its own motion, take such measures as the court considers appropriate, which may include the imposition of sanctions.

(B) BY SERVING PARTY.—If paragraph (1) is violated by the party who served the report, paragraph (1) shall no longer apply to any party.

SEC. 308. EXPERT OPINIONS RELATING TO PHYSICIANS MAY BE PROVIDED ONLY BY ACTIVELY PRACTICING PHYSICIANS.

(a) IN GENERAL.—A physician-related opinion may be provided only by an actively practicing physician who is determined by the court to be qualified on the basis of training and experience to render that opinion.

1 (b) CONSIDERATIONS REQUIRED.—In determining
2 whether an actively practicing physician is qualified under
3 subsection (a), the court shall, except on good cause
4 shown, consider whether that physician is board-certified,
5 or has other substantial training, in an area of medical
6 practice relevant to the health care to which the opinion
7 relates.

8 (c) DEFINITIONS.—In this section:

9 (1) The term ''actively practicing physician''
10 means an individual who—

11 (A) is licensed to practice medicine in the
12 United States or, if the individual is a defend-
13 ant providing a physician-related opinion with
14 respect to the health care provided by that de-
15 fendant, is a graduate of a medical school ac-
16 credited by the Liaison Committee on Medical
17 Education or the American Osteopathic Asso-
18 ciation;

19 (B) is practicing medicine when the opin-
20 ion is rendered, or was practicing medicine
21 when the health care was provided; and

22 (C) has knowledge of the accepted stand-
23 ards of care for the health care to which the
24 opinion relates.

(2) The term ''physician-related opinion'' means an expert opinion as to any one or more of the following:

(A) The standard of care applicable to a physician.

(B) Whether a physician failed to meet such a standard of care.

(C) Whether there was a causal relationship between such a failure by a physician and the injury or death of an individual.

(3) The term ''practicing medicine'' includes training residents or students at an accredited school of medicine or osteopathy, and serving as a consulting physician to other physicians who provide direct patient care.

SEC. 309. PAYMENT OF FUTURE DAMAGES ON PERIODIC OR ACCRUAL BASIS.

(a) IN GENERAL.—When future damages are awarded against a health care practitioner to a person for the injury or death of an individual as a result of health care, and the present value of those future damages is $100,000 or more, that health care practitioner may move that the court order payment on a periodic or accrual basis of those damages. On such a motion, the court—

1 (1) shall order that payment be made on an ac-
2 crual basis of future damages described in sub-
3 section (b)(1); and
4 (2) may order that payment be made on a peri-
5 odic or accrual basis of any other future damages
6 that the court considers appropriate.
7 (b) FUTURE DAMAGES DEFINED.—In this section,
8 the term ''future damages'' means—
9 (1) the future costs of medical, health care, or
10 custodial services;
11 (2) noneconomic damages, such as pain and
12 suffering or loss of consortium;
13 (3) loss of future earnings; and
14 (4) any other damages incurred after the award
15 is made.

16 **SEC. 310. UNANIMOUS JURY REQUIRED FOR PUNITIVE OR**
17 **EXEMPLARY DAMAGES.**

18 When an individual is injured or dies as the result
19 of health care, a jury may not award punitive or exemplary
20 damages against a health care practitioner or health care
21 institution unless the jury is unanimous with regard to
22 both the liability of that party for such damages and the
23 amount of the award of such damages.

SEC. 311. PROPORTIONATE LIABILITY.

When an individual is injured or dies as the result of health care and a person is entitled to damages for that injury or death, each person responsible is liable only for a proportionate share of the total damages that directly corresponds to that person's proportionate share of the total responsibility.

SEC. 312. DEFENSE-INITIATED SETTLEMENT PROCESS.

(a) IN GENERAL.—In a civil action, to the extent the civil action seeks damages for the injury or death of an individual as the result of health care, a health care practitioner or health care institution against which such damages are sought may serve one or more qualified settlement offers under this section to a person seeking such damages. If the person seeking such damages does not accept such an offer, that person may thereafter serve one or more qualified settlement offers under this section to the party whose offer was not accepted.

(b) QUALIFIED SETTLEMENT OFFER.—A qualified settlement offer under this section is an offer, in writing, to settle the matter as between the offeror and the offeree, which—

(1) specifies that it is made under this section;

(2) states the terms of settlement; and

(3) states the deadline within which the offer must be accepted.

1 (c) EFFECT OF OFFER.—If the offeree of a qualified
2 settlement offer does not accept that offer, and thereafter
3 receives a judgment at trial that, as between the offeror
4 and the offeree, is significantly less favorable than the
5 terms of settlement in that offer, that offeree is respon-
6 sible for those litigation costs reasonably incurred, after
7 the deadline stated in the offer, by the offeror to respond
8 to the claims of the offeree.

9 (d) LITIGATION COSTS DEFINED.—In this section,
10 the term ''litigation costs'' include court costs, filing fees,
11 expert witness fees, attorney fees, and any other costs di-
12 rectly related to carrying out the litigation.

13 (e) SIGNIFICANTLY LESS FAVORABLE DEFINED.—
14 For purposes of this section, a judgment is significantly
15 less favorable than the terms of settlement if—

16 (1) in the case of an offeree seeking damages,
17 the offeree's award at trial is less than 80 percent
18 of the value of the terms of settlement; and

19 (2) in the case of an offeree against whom dam-
20 ages are sought, the offeror's award at trial is more
21 than 120 percent of the value of the terms of settle-
22 ment.

1 **SEC. 313. STATUTE OF LIMITATIONS; STATUTE OF REPOSE.**

2 (a) STATUTE OF LIMITATIONS.—When an individual
3 is injured or dies as the result of health care, the statute
4 of limitations shall be as follows:

5 (1) INDIVIDUALS OF AGE 12 AND OVER.—If the
6 individual has attained the age of 12 years, the
7 claim must be brought either—

8 (A) within 2 years after the negligence oc-
9 curred; or

10 (B) within 2 years after the health care on
11 which the claim is based is completed.

12 (2) INDIVIDUALS UNDER AGE 12.—If the indi-
13 vidual has not attained the age of 12 years, the
14 claim must be brought before the individual attains
15 the age of 14 years.

16 (b) STATUTE OF REPOSE.—When an individual is in-
17 jured or dies as the result of health care, the statute of
18 repose shall be as follows: The claim must be brought
19 within 10 years after the act or omission on which the
20 claim is based is completed.

21 (c) TOLLING.—

22 (1) STATUTE OF LIMITATIONS.—The statute of
23 limitations required by subsection (a) may be tolled
24 if applicable law so provides, except that it may not
25 be tolled on the basis of minority.

(2) STATUTE OF REPOSE.—The statute of repose required by subsection (b) may not be tolled for any reason.

SEC. 314. LIMITATION ON LIABILITY FOR GOOD SAMARITANS PROVIDING EMERGENCY HEALTH CARE.

(a) WILLFUL OR WANTON NEGLIGENCE REQUIRED.—A health care practitioner or health care institution that provides emergency health care on a Good Samaritan basis is not liable for damages caused by that care except for willful or wanton negligence or more culpable misconduct.

(b) GOOD SAMARITAN BASIS.—For purposes of this section, care is provided on a Good Samaritan basis if it is not provided for or in expectation of remuneration. Being entitled to remuneration is relevant to, but is not determinative of, whether it is provided for or in expectation of remuneration.

SEC. 315. DEFINITIONS.

In this division:

(1) HEALTH CARE INSTITUTION.—The term ''health care institution'' includes institutions such as—

(A) an ambulatory surgical center;

(B) an assisted living facility;

1 (C) an emergency medical services provider;
3 (D) a home health agency;
4 (E) a hospice;
5 (F) a hospital;
6 (G) a hospital system;
7 (H) an intermediate care facility for the mentally retarded;
9 (I) a nursing home; and
10 (J) an end stage renal disease facility.
11 (2) HEALTH CARE PRACTITIONER.—The term "health care practitioner" includes a physician and a physician entity.
14 (3) PHYSICIAN ENTITY.—The term "physician entity" includes—
16 (A) a partnership or limited liability partnership created by a group of physicians;
18 (B) a company created by physicians; and
19 (C) a nonprofit health corporation whose board is composed of physicians.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 401. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to interfere with the doctor-patient relationship or the practice of medicine.

SEC. 402. REPEAL OF FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Effective on the date of the enactment of this Act, section 804 of the American Recovery and Reinvestment Act of 2009 is repealed.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

SEC. 501. INCENTIVES FOR PREVENTION AND WELLNESS PROGRAMS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 LIMITATION ON EXCEPTION FOR WELLNESS PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

(1) IN GENERAL.—Section 702(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)(2)), as restored by section 2, is

1 amended by adding after and below subparagraph
2 (B) the following:
3 "In applying subparagraph (B), a group health plan
4 (or a health insurance issuer with respect to health
5 insurance coverage) may vary premiums and cost-
6 sharing by up to 50 percent of the value of the bene-
7 fits under the plan (or coverage) based on participa-
8 tion in a standards-based wellness program.".
9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall apply to plan years beginning
11 more than 1 year after the date of the enactment of
12 this Act.
13 (b) CONFORMING AMENDMENTS TO PHSA.—
14 (1) GROUP MARKET RULES.—
15 (A) IN GENERAL.—Section 2702(b)(2) of
16 the Public Health Service Act (42 U.S.C.
17 300gg–1(b)(2)), as restored by section 2, is
18 amended by adding after and below subpara-
19 graph (B) the following:
20 "In applying subparagraph (B), a group health plan
21 (or a health insurance issuer with respect to health
22 insurance coverage) may vary premiums and cost-
23 sharing by up to 50 percent of the value of the bene-
24 fits under the plan (or coverage) based on participa-
25 tion in a standards-based wellness program.".

1 (B) EFFECTIVE DATE.—The amendment
2 made by subparagraph (A) shall apply to plan
3 years beginning more than 1 year after the date
4 of the enactment of this Act.
5 (2) INDIVIDUAL MARKET RULES RELATING TO
6 GUARANTEED AVAILABILITY.—
7 (A) IN GENERAL.—Section 2741(f) of the
8 Public Health Service Act (42 U.S.C. 300gg–
9 1(b)(2)), as restored by section 2, is amended
10 by adding after and below paragraph (1) the
11 following:
12 ''In applying paragraph (2), a health insurance issuer may
13 vary premiums and cost-sharing under health insurance
14 coverage by up to 50 percent of the value of the benefits
15 under the coverage based on participation in a standards-
16 based wellness program.''.
17 (B) EFFECTIVE DATE.—The amendment
18 made by paragraph (1) shall apply to health in-
19 surance coverage offered or renewed on and
20 after the date that is 1 year after the date of
21 the enactment of this Act.
22 (c) CONFORMING AMENDMENTS TO IRC.—
23 (1) IN GENERAL.—Section 9802(b)(2) of the
24 Internal Revenue Code of 1986,as restored by sec-

tion 2, is amended by adding after and below subparagraph (B) the following:

"In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

DIVISION F—PROTECTING TAXPAYERS

SEC. 601. PERMANENTLY PROHIBITING TAXPAYER FUNDED ABORTIONS AND ENSURING CONSCIENCE PROTECTIONS.

Title 1 of the United States Code is amended by adding at the end the following new chapter:

1 **"CHAPTER 4—PERMANENTLY PROHIB-**
2 **ITING TAXPAYER FUNDED ABORTIONS**
3 **AND ENSURING CONSCIENCE PROTEC-**
4 **TIONS**

5 **"SEC. 301. PROHIBITION ON FUNDING FOR ABORTIONS.**

6 ''No funds authorized or appropriated by Federal
7 law, and none of the funds in any trust fund to which
8 funds are authorized or appropriated by Federal law, shall
9 be expended for any abortion.

10 **"SEC. 302. PROHIBITION ON FUNDING FOR HEALTH BENE-**
11 **FITS PLANS THAT COVER ABORTION.**

12 ''None of the funds authorized or appropriated by
13 federal law, and none of the funds in any trust fund to
14 which funds are authorized or appropriated by federal law,
15 shall be expended for a health benefits plan that includes
16 coverage of abortion.

17 **"SEC. 303. TREATMENT OF ABORTIONS RELATED TO RAPE,**
18 **INCEST, OR PRESERVING THE LIFE OF THE**
19 **MOTHER.**

20 ''The limitations established in sections 301 and 302
21 shall not apply to an abortion—
22 ''(1) if the pregnancy is the result of an act of
23 rape or incest; or
24 ''(2) in the case where a woman suffers from a
25 physical disorder, physical injury, or physical illness

that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.

"SEC. 304. CONSTRUCTION RELATING TO SUPPLEMENTAL COVERAGE.

"Nothing in this chapter shall be construed as prohibiting any individual, entity, or State or locality from purchasing separate supplemental abortion plan or coverage that includes abortion so long as such plan or coverage is paid for entirely using only funds not authorized or appropriated by federal law and such plan or coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

"SEC. 305. CONSTRUCTION RELATING TO THE USE OF NON-FEDERAL FUNDS FOR HEALTH COVERAGE.

"Nothing in this chapter shall be construed as restricting the ability of any managed care provider or other organization from offering abortion coverage or the ability of a State to contract separately with such a provider or organization for such coverage with funds not authorized or appropriated by federal law and such plan or coverage shall not be purchased using matching funds required for

a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

"SEC. 306. NO GOVERNMENT DISCRIMINATION AGAINST CERTAIN HEALTH CARE ENTITIES.

"(a) IN GENERAL.—No funds authorized or appropriated by federal law may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

"(b) HEALTH CARE ENTITY DEFINED.—For purposes of this section, the term 'health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.".

SEC. 602. IMPROVED ENFORCEMENT OF THE MEDICARE AND MEDICAID SECONDARY PAYER PROVISIONS.

(a) MEDICARE.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in coordination with the Inspector General of the Department of Health and Human Services, shall provide through the Coordination of

1 Benefits Contractor for the identification of in-
2 stances where the Medicare program should be, but
3 is not, acting as a secondary payer to an individual's
4 private health benefits coverage under section
5 1862(b) of the Social Security Act (42 U.S.C.
6 1395y(b)).

7 (2) UPDATING PROCEDURES.—The Secretary
8 shall update procedures for identifying and resolving
9 credit balance situations which occur under the
10 Medicare program when payment under such title
11 and from other health benefit plans exceed the pro-
12 viders' charges or the allowed amount.

13 (3) REPORT ON IMPROVED ENFORCEMENT.—
14 Not later than 1 year after the date of the enact-
15 ment of this Act, the Secretary shall submit a report
16 to Congress on progress made in improved enforce-
17 ment of the Medicare secondary payer provisions, in-
18 cluding recoupment of credit balances.

19 (b) MEDICAID.—Section 1903 of the Social Security
20 Act (42 U.S.C. 1396b) is amended by adding at the end
21 the following new subsection:

22 "(aa) ENFORCEMENT OF PAYER OF LAST RESORT
23 PROVISIONS.—

24 "(1) SUBMISSION OF STATE PLAN AMEND-
25 MENT.—Each State shall submit, not later than 1

1 year after the date of the enactment of this sub-
2 section, a State plan amendment that details how
3 the State will become fully compliant with the re-
4 quirements of section 1902(a)(25).

5 ‘‘(2) BONUS FOR COMPLIANCE.—If a State sub-
6 mits a timely State plan amendment under para-
7 graph (1) that the Secretary determines provides for
8 full compliance of the State with the requirements of
9 section 1902(a)(25), the Secretary shall provide for
10 an additional payment to the State of $1,000,000. If
11 a State certifies, to the Secretary's satisfaction, that
12 it is already fully compliant with such requirements,
13 such amount shall be increased to $2,000,000.

14 ‘‘(3) REDUCTION FOR NONCOMPLIANCE.—If a
15 State does not submit such an amendment, the Sec-
16 retary shall reduce the Federal medical assistance
17 percentage otherwise applicable under this title by 1
18 percentage point until the State submits such an
19 amendment.

20 ‘‘(4) ONGOING REDUCTION.—If at any time the
21 Secretary determines that a State is not in compli-
22 ance with section 1902(a)(25), regardless of the sta-
23 tus of the State's submission of a State plan amend-
24 ment under this subsection or previous determina-
25 tions of compliance such requirements, the Secretary

shall reduce the Federal medical assistance percentage otherwise applicable under this title for the State by 1 percentage point during the period of non-compliance as determined by the Secretary.''.

SEC. 603. STRENGTHEN MEDICARE PROVIDER ENROLLMENT STANDARDS AND SAFEGUARDS.

(a) PROTECTING AGAINST THE FRAUDULENT USE OF MEDICARE PROVIDER NUMBERS.—Subject to subsection (c)(2)—

(1) SCREENING NEW PROVIDERS.—As a condition of a provider of services or a supplier, including durable medical equipment suppliers and home health agencies, applying for the first time for a provider number under the Medicare program under title XVIII of the Social Security Act and before granting billing privileges under such title, the Secretary of Health and Human Services shall screen the provider or supplier for a criminal background or other financial or operational irregularities through fingerprinting, licensure checks, site-visits, other database checks.

(2) APPLICATION FEES.—The Secretary shall impose an application charge on such a provider or supplier in order to cover the Secretary's costs in performing the screening required under paragraph

1 (1) and that is revenue neutral to the Federal gov-
2 ernment.
3 (3) PROVISIONAL APPROVAL.—During an ini-
4 tial, provisional period (specified by the Secretary)
5 in which such a provider or supplier has been issued
6 such a number, the Secretary shall provide enhanced
7 oversight of the activities of such provider or sup-
8 plier under the Medicare program, such as through
9 prepayment review and payment limitations.
10 (4) PENALTIES FOR FALSE STATEMENTS.—In
11 the case of a provider or supplier that makes a false
12 statement in an application for such a number, the
13 Secretary may exclude the provider or supplier from
14 participation under the Medicare program, or may
15 impose a civil money penalty (in the amount de-
16 scribed in section 1128A(a)(4) of the Social Security
17 Act), in the same manner as the Secretary may im-
18 pose such an exclusion or penalty under sections
19 1128 and 1128A, respectively, of such Act in the
20 case of knowing presentation of a false claim de-
21 scribed in section 1128A(a)(1)(A) of such Act.
22 (5) DISCLOSURE REQUIREMENTS.—With re-
23 spect to approval of such an application, the Sec-
24 retary—

1 (A) shall require applicants to disclose pre-
2 vious affiliation with enrolled entities that have
3 uncollected debt related to the Medicare or
4 Medicaid programs;
5 (B) may deny approval if the Secretary de-
6 termines that these affiliations pose undue risk
7 to the Medicare or Medicaid program, subject
8 to an appeals process for the applicant as deter-
9 mined by the Secretary; and
10 (C) may implement enhanced safeguards
11 (such as surety bonds).
12 (b) MORATORIA.—The Secretary of Health and
13 Human Services may impose moratoria on approval of
14 provider and supplier numbers under the Medicare pro-
15 gram for new providers of services and suppliers as deter-
16 mined necessary to prevent or combat fraud a period of
17 delay for any one applicant cannot exceed 30 days unless
18 cause is shown by the Secretary.
19 (c) FUNDING.—
20 (1) IN GENERAL.—There are authorized to be
21 appropriated to carry out this section such sums as
22 may be necessary.
23 (2) CONDITION.—The provisions of paragraphs
24 (1) and (2) of subsection (a) shall not apply unless

and until funds are appropriated to carry out such provisions.

SEC. 604. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

(a) GREATER COORDINATION.—The Secretary of Health and Human Services shall provide for increased coordination between the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'') and its regional offices to ensure that providers of services and suppliers that have operated in one State and are excluded from participation in the Medicare program are unable to begin operation and participation in the Medicare program in another State.

(b) IMPROVED INFORMATION SYSTEMS.—

(1) IN GENERAL.—The Secretary shall improve information systems to allow greater integration between databases under the Medicare program so that—

(A) Medicare administrative contractors, fiscal intermediaries, and carriers have immediate access to information identifying providers and suppliers excluded from participation in the Medicare and Medicaid program and other Federal health care programs; and

1 (B) such information can be shared across
2 Federal health care programs and agencies, in-
3 cluding between the Departments of Health and
4 Human Services, the Social Security Adminis-
5 tration, the Department of Veterans Affairs,
6 the Department of Defense, the Department of
7 Justice, and the Office of Personnel Manage-
8 ment.

9 (c) MEDICARE/MEDICAID "ONE PI" DATABASE.—
10 The Secretary shall implement a database that includes
11 claims and payment data for all components of the Medi-
12 care program and the Medicaid program.

13 (d) AUTHORIZING EXPANDED DATA MATCHING.—
14 Notwithstanding any provision of the Computer Matching
15 and Privacy Protection Act of 1988 to the contrary—

16 (1) the Secretary and the Inspector General in
17 the Department of Health and Human Services may
18 perform data matching of data from the Medicare
19 program with data from the Medicaid program; and

20 (2) the Commissioner of Social Security and the
21 Secretary may perform data matching of data of the
22 Social Security Administration with data from the
23 Medicare and Medicaid programs.

24 (e) CONSOLIDATION OF DATABASES.—The Secretary
25 shall consolidate and expand into a centralized database

1 for individuals and entities that have been excluded from
2 Federal health care programs the Healthcare Integrity
3 and Protection Data Bank, the National Practitioner
4 Data Bank, the List of Excluded Individuals/Entities, and
5 a national patient abuse/neglect registry.

6 (f) COMPREHENSIVE PROVIDER DATABASE.—

7 (1) ESTABLISHMENT.—The Secretary shall es-
8 tablish a comprehensive database that includes infor-
9 mation on providers of services, suppliers, and re-
10 lated entities participating in the Medicare program,
11 the Medicaid program, or both. Such database shall
12 include, information on ownership and business rela-
13 tionships, history of adverse actions, results of site
14 visits or other monitoring by any program.

15 (2) USE.—Prior to issuing a provider or sup-
16 plier number for an entity under the Medicare pro-
17 gram, the Secretary shall obtain information on the
18 entity from such database to assure the entity quali-
19 fies for the issuance of such a number.

20 (g) COMPREHENSIVE SANCTIONS DATABASE.—The
21 Secretary shall establish a comprehensive sanctions data-
22 base on sanctions imposed on providers of services, sup-
23 pliers, and related entities. Such database shall be over-
24 seen by the Inspector General of the Department of
25 Health and Human Services and shall be linked to related

1 databases maintained by State licensure boards and by
2 Federal or State law enforcement agencies.
3 (h) ACCESS TO CLAIMS AND PAYMENT DATA-
4 BASES.—The Secretary shall ensure that the Inspector
5 General of the Department of Health and Human Services
6 and Federal law enforcement agencies have direct access
7 to all claims and payment databases of the Secretary
8 under the Medicare or Medicaid programs.
9 (i) CIVIL MONEY PENALTIES FOR SUBMISSION OF
10 ERRONEOUS INFORMATION.—In the case of a provider of
11 services, supplier, or other entity that submits erroneous
12 information that serves as a basis for payment of any enti-
13 ty under the Medicare or Medicaid program, the Secretary
14 may impose a civil money penalty of not to exceed $50,000
15 for each such erroneous submission. A civil money penalty
16 under this subsection shall be imposed and collected in the
17 same manner as a civil money penalty under subsection
18 (a) of section 1128A of the Social Security Act is imposed
19 and collected under that section.

○