I

112TH CONGRESS
1ST SESSION

H. R. 3000

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 21, 2011

Mr. PRICE of Georgia (for himself, Mr. BURTON of Indiana, Mr. WILSON of South Carolina, Mr. SESSIONS, and Mr. FLEMING) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, the Judiciary, Natural Resources, Rules, House Administration, Appropriations, Oversight and Government Reform, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Empowering Patients First Act''.

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

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

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH INSURANCE COVERAGE

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

TITLE II—HEALTH INSURANCE POOLING MECHANISMS FOR INDIVIDUALS

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

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

Subtitle B—Federal Block Grants for State Insurance Expenditures

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

Subtitle C—Health Care Access and Availability

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

Subtitle D—Small Business Health Fairness

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

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

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

TITLE IV—SAFETY NET REFORMS

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

TITLE V—MEDICAL LIABILITY REFORMS

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

TITLE VI—WELLNESS AND PREVENTION

Sec. 601. Providing financial incentives for treatment compliance.

TITLE VII—TRANSPARENCY AND INSURANCE REFORM MEASURES

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

TITLE VIII—QUALITY

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

TITLE IX—STATE TRANSPARENCY PLAN PORTAL

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

TITLE X—PATIENT FREEDOM OF CHOICE

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

TITLE XI—INCENTIVES TO REDUCE PHYSICIAN SHORTAGES

Subtitle A—Federally Supported Student Loan Funds for Medical Students

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

Subtitle B—Loan Forgiveness for Primary Care Providers

Sec. 1111. Loan forgiveness for primary care providers.

TITLE XII—QUALITY HEALTH CARE COALITION

Sec. 1201. Quality Health Care Coalition.

TITLE XIII—OFFSETS

Subtitle A—Discretionary Spending Limits

Sec. 1301. Discretionary spending limits.

Subtitle B—Savings From Health Care Efficiencies

Sec. 1311. Medicare DSH report and payment adjustments in response to coverage expansion.
Sec. 1312. Reduction in Medicaid DSH.

Subtitle C—Fraud, Waste, and Abuse

Sec. 1321. Provide adequate funding to HHS OIG and HCFAC.
Sec. 1322. Improved enforcement of the Medicare secondary payor provisions.
Sec. 1323. Strengthen Medicare provider enrollment standards and safeguards.
Sec. 1324. Tracking banned providers across State lines.

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

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

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

or revived as if such title and subtitle had not been enacted.

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH INSURANCE COVERAGE

SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COSTS OF LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"SEC. 36B. HEALTH INSURANCE COSTS OF LOW-INCOME INDIVIDUALS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A the aggregate amount paid by the taxpayer for coverage of the taxpayer and the taxpayer's qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

''(b) LIMITATIONS.—

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

''(A) the sum of the monthly limitations for months during such taxable year that the

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

"(B) the aggregate premiums paid by the taxpayer for the taxable year for coverage described in subsection (a).

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is the credit percentage of 1/12 of the sum of—

"(A) $2,000 for coverage of the taxpayer ($4,000 in the case of a joint return for coverage of the taxpayer and the taxpayer's spouse), and

"(B) $500 for coverage of each dependent of the taxpayer.

"(3) CREDIT PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this section, the term 'credit percentage' means 100 percent reduced by 1 percentage point for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the threshold amount.

"(B) THRESHOLD AMOUNT.—For purposes of this paragraph, the term 'threshold amount' means, with respect to any taxpayer for any taxable year, 200 percent of the Federal pov-

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

''(4) ONLY 2 DEPENDENTS TAKEN INTO ACCOUNT.—Not more than 2 dependents of the taxpayer may be taken into account under paragraphs (2)(C) and (3)(B).

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

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50.

''(c) ELIGIBLE COVERAGE MONTH.—For purposes of this section, the term 'eligible coverage month' means, with respect to any individual, any month if, as of the first day of such month, the individual—

''(1) is covered by qualified health insurance,

''(2) does not have other specified coverage, and

''(3) is not imprisoned under Federal, State, or local authority.

''(d) QUALIFYING FAMILY MEMBER.—For purposes of this section, the term 'qualifying family member' means—

''(1) in the case of a joint return, the taxpayer's spouse, and

''(2) any dependent of the taxpayer.

''(e) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' means health insurance coverage (other than excepted benefits as defined in section 9832(c)) which constitutes medical care.

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

''(1) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

''(A) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

''(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

''(2) CERTAIN OTHER COVERAGE.—Such individual—

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

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

''(C) in entitled to receive benefits under chapter 17 of title 38, United States Code, or

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

''(g) SPECIAL RULES.—

''(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT; RECAPTURE OF EXCESS ADVANCE PAYMENTS.—With respect to any taxable year—

''(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, and

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

"(i) the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, over

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

"(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining—

"(A) any deduction allowed under section 162(l), 213, or 224, or

"(B) any credit allowed under section 35.

"(3) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) or from a health savings account (as defined in section 223(d)) shall not be taken into account under subsection (a).

"(4) DENIAL OF CREDIT TO DEPENDENTS AND NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—

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

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

"(B) a dependent with respect to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(5) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

"(6) TREATMENT OF PAYMENTS.—For purposes of this section—

"(A) PAYMENTS BY SECRETARY.—Payments made by the Secretary on behalf of any individual under section 7529 (relating to advance payment of credit for health insurance costs of low-income individuals) shall be treated as having been made by the taxpayer on the

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

''(B) PAYMENTS BY TAXPAYER.—Payments made by the taxpayer for eligible coverage months shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

''(7) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050W, and section 7529.''.

(b) CONFORMING AMENDMENTS.—

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

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

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

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

(d) SENSE OF CONGRESS.—It is the sense of Congress that the cost of the advanceable refundable credit under sections 36B and 7529 of the Internal Revenue

Code of 1986, as added by this title, will be offset by savings derived from the provisions of title XIII.

SEC. 102. ADVANCE PAYMENT OF CREDIT AS PREMIUM PAYMENT FOR QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following:

"SEC. 7529. ADVANCE PAYMENT OF CREDIT AS PREMIUM PAYMENT FOR QUALIFIED HEALTH INSURANCE.

''(a) GENERAL RULE.—Not later than January 1, 2012, the Secretary shall establish a program for making payments to providers of qualified health insurance (as defined in section 36B(e)) on behalf of taxpayers eligible for the credit under section 36B. Except as otherwise provided by the Secretary, such payments shall be made on the basis of the adjusted gross income of the taxpayer for the preceding taxable year.

''(b) CERTIFICATION PROCESS AND PROOF OF COVERAGE.—For purposes of this section, payments may be made pursuant to subsection (a) only with respect to individuals for whom a qualified health insurance costs credit eligibility certificate is in effect.''.

(b) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—

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

''(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The Secretary may, on behalf of taxpayers eligible for the credit under section 36B, disclose to a provider of qualified health insurance (as defined in section 36(e)), and persons acting on behalf of such provider, return information with respect to any such taxpayer only to the extent necessary (as prescribed by regulations issued by the Secretary) to carry out the program established by section 7529 (relating to advance payment of credit as premium payment for qualified health insurance).''.

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

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

(c) INFORMATION REPORTING.—

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

''SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH INSURANCE COSTS OF LOW-INCOME INDIVIDUALS.

''(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7529 (relating to advance payment of credit as premium payment for qualified health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

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

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

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

"(B) the number of months for which amounts were entitled to be received with respect to such individual under section 7529 (relating to advance payment of credit as premium payment for qualified health insurance),

"(C) the amount entitled to be received for each such month, and

"(D) such other information as the Secretary may prescribe.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

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

The written statement required under the preceding sentence shall be furnished on or before January 31 of the

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

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by inserting after clause (xxiii) the following new clause:

''(xxiv) section 6050X (relating to returns relating to credit for health insurance costs of low-income individuals), and''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting '', or'', and by adding after subparagraph (FF) the following new subparagraph:

''(GG) section 6050X (relating to returns relating to credit for health insurance costs of low-income individuals).''.

(d) CLERICAL AMENDMENTS.—

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

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

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

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

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

SEC. 103. ELECTION OF TAX CREDIT INSTEAD OF ALTERNATIVE GOVERNMENT OR GROUP PLAN BENEFITS.

(a) IN GENERAL.—Notwithstanding any other provision of law, an individual who is otherwise eligible for benefits under a health program (as defined in subsection (c)) may elect, in a form and manner specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury, to receive a tax credit described in section 36B of the Internal Revenue Code of 1986 (which may be used for the purpose of health insurance coverage) in lieu of receiving any benefits under such program.

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

(c) HEALTH PROGRAM DEFINED.—For purposes of this section, the term ''health program'' means any of the following:

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

(2) MEDICAID.—The Medicaid program under title XIX of such Act (including such a program operating under a Statewide waiver under section 1115 of such Act).

(3) SCHIP.—The State children's health insurance program under title XXI of such Act.

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

(5) VETERANS BENEFITS.—Coverage for benefits under chapter 17 of title 38, United States Code.

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

(7) SUBSIDIZED GROUP HEALTH PLANS.—Coverage under a group health plan (within the meaning of section 5000(b)(1)) which is subsidized by the employer.

(d) OTHER SOCIAL SECURITY BENEFITS NOT WAIVED.—An election to waive the benefits described in subsection (c)(1) shall not result in the waiver of any other benefits under the Social Security Act.

SEC. 104. DEDUCTION FOR QUALIFIED HEALTH INSURANCE COSTS OF INDIVIDUALS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. COSTS OF QUALIFIED HEALTH INSURANCE.

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

''(b) LIMITATION.—In the case of any taxpayer for any taxable year, the deduction under subsection (a) shall not exceed an amount that would cause the taxpayer's Federal income tax liability to be reduced by more than

the average value of the national health exclusion for employer sponsored insurance as determined by calculating the value of the exclusion for each household followed by calculating the average of those values.

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' has the meaning given such term by section 36B(e).

''(d) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a). Any amount taken into account in determining the credit allowed under section 35 or 36B shall not be taken into account for purposes of this section.

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''.

(b) DEDUCTION ALLOWED IN COMPUTING ADJUSTED GROSS INCOME.—Subsection (a) of section 62 of

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

''(22) COSTS OF QUALIFIED HEALTH INSURANCE.—The deduction allowed by section 224.''.

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

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

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

SEC. 105. LIMITATION ON ABORTION FUNDING.

No funds authorized under, or credits or deductions allowed under the Internal Revenue Code of 1986 by reason of, this Act (or any amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a 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, or unless the pregnancy is the result of an act of rape or incest.

SEC. 106. NO GOVERNMENT DISCRIMINATION AGAINST CERTAIN HEALTH CARE ENTITIES.

(a) NON-DISCRIMINATION.—A Federal agency or program, and any State or local government that receives Federal financial assistance under this Act or any amendment made by this Act (either directly or indirectly), may not subject any individual or institutional 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.

(c) REMEDIES.—

(1) IN GENERAL.—The courts of the United States shall have jurisdiction to prevent and redress actual or threatened violations of this section by issuing any form of legal or equitable relief, including—

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

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

to a State or local government, or to a specific offending agency or program of a State or local government, until such time as the conduct prohibited by this section has ceased.

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

(A) any health care entity that has standing to complain of an actual or threatened violation of this section; or

(B) the Attorney General of the United States.

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

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

(2) subject to paragraph (3), to pursue the investigation of such complaints in coordination with the Attorney General; and

(3) in the case of a complaint related to a Federal agency (other than with respect to the Department of Health and Human Services) or program administered through such other agency or any State or local government receiving Federal financial

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

SEC. 107. EQUAL EMPLOYER CONTRIBUTION RULE TO PROMOTE CHOICE.

(a) EXCISE TAX FOR FAILURE TO PROVIDE CONTRIBUTION ELECTION.—Section 5000 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(e) HEALTH CARE CONTRIBUTION ELECTION.—

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

''(2) CONTRIBUTION ELECTION.—The requirement of this paragraph is met with respect to a group health plan if any employee of an employer (who but for this paragraph would be covered by such plan) may elect to have the employer or employee organization pay an amount which is not less than the contribution amount to any provider of health insurance coverage (other than excepted benefits as defined in section 9832(c)) which constitutes medical care of the individual or individual's spouse or dependents in lieu of such group health plan cov-

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

''(3) PRE-EXISTING CONDITIONS.—

''(A) IN GENERAL.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer if, under such plan the requirements of section 9801 are met with respect to the participant or beneficiary.

''(B) ENFORCEMENT WITH RESPECT TO INDIVIDUAL ELECTION.—For purposes of subparagraph (A), any health insurance coverage with respect to the participant or beneficiary shall be treated as health insurance coverage under a group health plan to which section 9801 applies.

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

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

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

''(6) APPLICATION TO FEHBP.—Notwithstanding any other provision of law, the Office of Personnel Management shall carry out the health benefits program under chapter 89 of title 5, United States Code, consistent with the requirements of this subsection.''.

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

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

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

''(2) the aggregate amount of such contributions is estimated to be equal to the aggregate amount of such contributions if this subsection did not apply.''.

(c) ERISA CONFORMING AMENDMENTS.—

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

''(e) HEALTH CARE CONTRIBUTION ELECTION.—

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

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

''(B) with respect to which the requirements of paragraphs (2) and (3) are met.

''(2) CONTRIBUTION ELECTION.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer under a group health plan if, under such plan—

''(A) the participant may elect such coverage for any period of coverage in lieu of

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

''(B) in the case of such an election, the plan sponsor is required to pay to such issuer for the elected coverage for such period an amount which is not less than the contribution amount for such health insurance coverage otherwise provided under such plan for such period.

''(3) PRE-EXISTING CONDITIONS.—

''(A) IN GENERAL.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer if, under such plan the requirements of section 701 are met with respect to the participant or beneficiary.

''(B) ENFORCEMENT WITH RESPECT TO INDIVIDUAL ELECTION.—For purposes of subparagraph (A), any health insurance coverage with respect to the participant or beneficiary shall be treated as health insurance coverage under a group health plan to which section 701 applies.

''(4) CONTRIBUTION AMOUNT.—

"(A) IN GENERAL.—For purposes of this section, the term 'contribution amount' means, with respect to any period of health insurance coverage offered to a participant or beneficiary, the portion of the applicable premium of such participant or beneficiary under such plan which is not paid by such participant or beneficiary. In the case that the employer offers more than one group health plan, the contribution amount shall be the average amount of the applicable premiums under such plans.

"(B) APPLICABLE PREMIUM.—For purposes of subparagraph (A), the term 'applicable premium' means, with respect to any period of health insurance coverage of a participant or beneficiary under a group health plan, the cost to the plan for such period of such coverage for similarly situated beneficiaries (without regard to whether such cost is paid by the plan sponsor or the participant or beneficiary).".

(2) EXEMPTION FROM FIDUCIARY LIABILITY.—Section 404 of such Act (29 U.S.C. 1104) is amended by adding at the end the following new subsection:

''(e) The plan sponsor of a group health plan (as defined in section 733(a)) shall not be treated as breaching any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title in the case of any individual who is a participant or beneficiary under such plan solely because of the extent to which the plan sponsor provides, in the case of such individual, some or all of such benefits by means of payment of contribution amounts pursuant to a contribution election under section 732(e), irrespective of the amount or type of benefits that would otherwise be provided to such individual under such plan.''.

(d) EXCEPTION FROM HIPAA REQUIREMENTS UNDER IRC FOR BENEFITS PROVIDED UNDER HEALTH CARE CONTRIBUTION ELECTION.—Section 9831 of the Internal Revenue Code of 1986 (relating to general exceptions) is amended by adding at the end the following new subsection:

''(d) HEALTH CARE CONTRIBUTION ELECTION.—

''(1) IN GENERAL.—The requirements of this chapter shall not apply in the case of health insurance coverage (other than excepted benefits as defined in section 9832(c))—

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

''(B) with respect to which the requirements of paragraphs (2) and (3) are met.

''(2) CONTRIBUTION ELECTION.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer under a group health plan if, under such plan—

''(A) the participant may elect such coverage for any period of coverage in lieu of health insurance coverage otherwise provided under such plan for such period, and

''(B) in the case of such an election, the plan sponsor is required to pay to such issuer for the elected coverage for such period an amount which is not less than the contribution amount for such health insurance coverage otherwise provided under such plan for such period.

''(3) PRE-EXISTING CONDITIONS.—

''(A) IN GENERAL.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer if, under such plan the requirements of section

9801 are met with respect to the participant or beneficiary.

''(B) ENFORCEMENT WITH RESPECT TO INDIVIDUAL ELECTION.—For purposes of subparagraph (A), any health insurance coverage with respect to the participant or beneficiary shall be treated as health insurance coverage under a group health plan to which section 9801 applies.

''(4) CONTRIBUTION AMOUNT.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'contribution amount' means, with respect to any period of health insurance coverage offered to a participant or beneficiary, the portion of the applicable premium of such participant or beneficiary under such plan which is not paid by such participant or beneficiary. In the case that the employer offers more than one group health plan, the contribution amount shall be the average amount of the applicable premiums under such plans.

''(B) APPLICABLE PREMIUM.—For purposes of subparagraph (A), the term 'applicable premium' means, with respect to any period of health insurance coverage of a participant or

beneficiary under a group health plan, the cost to the plan for such period of such coverage for similarly situated beneficiaries (without regard to whether such cost is paid by the plan sponsor or the participant or beneficiary).''.

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

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

''(e) HEALTH CARE CONTRIBUTION ELECTION.—

''(1) IN GENERAL.—The requirements of subparts 1 through 3 shall not apply in the case of health insurance coverage (other than excepted benefits as defined in section 9832(c) of the Internal Revenue Code of 1986)—

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

''(B) with respect to which the requirements of paragraphs (2) and (3) are met.

''(2) CONTRIBUTION ELECTION.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer under a group health plan if, under such plan—

''(A) the participant may elect such coverage for any period of coverage in lieu of health insurance coverage otherwise provided under such plan for such period, and

''(B) in the case of such an election, the plan sponsor is required to pay to such issuer for the elected coverage for such period an amount which is not less than the contribution amount for such health insurance coverage otherwise provided under such plan for such period.

''(3) PRE-EXISTING CONDITIONS.—

''(A) IN GENERAL.—The requirement of this paragraph is met with respect to health insurance coverage provided to a participant or beneficiary by any health insurance issuer if, under such plan the requirements of section 2701 are met with respect to the participant or beneficiary.

''(B) ENFORCEMENT WITH RESPECT TO INDIVIDUAL ELECTION.—For purposes of subparagraph (A), any health insurance coverage with respect to the participant or beneficiary shall be treated as health insurance coverage under a group health plan to which section 2701 applies.

''(4) CONTRIBUTION AMOUNT.—

''(A) IN GENERAL.—For purposes of this section, the term 'contribution amount' means, with respect to any period of health insurance coverage offered to a participant or beneficiary, the portion of the applicable premium of such participant or beneficiary under such plan which is not paid by such participant or beneficiary. In the case that the employer offers more than one group health plan, the contribution amount shall be the average amount of the applicable premiums under such plans.

''(B) APPLICABLE PREMIUM.—For purposes of subparagraph (A), the term 'applicable premium' means, with respect to any period of health insurance coverage of a participant or beneficiary under a group health plan, the cost to the plan for such period of such coverage for

similarly situated beneficiaries (without regard to whether such cost is paid by the plan sponsor or the participant or beneficiary).''.

SEC. 108. LIMITATIONS ON STATE RESTRICTIONS ON EMPLOYER AUTO-ENROLLMENT.

(a) IN GENERAL.—No State shall establish a law that prevents an employer from instituting auto-enrollment which meets the requirements of subsection (b) for coverage of a participant or beneficiary under a group health plan, or health insurance coverage offered in connection with such a plan, so long as the participant or beneficiary has the option of declining such coverage.

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

(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll such employee into the employment-based health benefits plan for individual coverage under the plan option with the lowest applicable employee premium.

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

fered by such employer. An employer shall provide an employee with a 30-day period to make such an affirmative election before the employer may automatically enroll the employee in such a plan.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—Each employer described in paragraph (1) who automatically enrolls an employee into a plan as described in such paragraph shall provide the employees, within a reasonable period before the beginning of each plan year (or, in the case of new employees, within a reasonable period before the end of the enrollment period for such a new employee), written notice of the employees' rights and obligations relating to the automatic enrollment requirement under such paragraph. Such notice must be comprehensive and understood by the average employee to whom the automatic enrollment requirement applies.

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

ployer involved, the notice must explain which level of benefits and employee premium level the employee will be automatically enrolled in the absence of an affirmative election by the employee.

(c) CONSTRUCTION.—Nothing in this section shall be construed to supersede State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll or the sponsoring of employer sponsored health insurance coverage except to the extent that such standard or requirement prevents an employer from instituting the auto-enrollment described in subsection (a).

(d) NON-APPLICATION TO EXCEPTED BENEFITS.—For purposes of this section, the term ''group health plan'' does not include excepted benefits (as defined in section 2781(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

SEC. 109. CREDIT FOR SMALL EMPLOYERS ADOPTING AUTO-ENROLLMENT AND DEFINED CONTRIBUTION OPTIONS.

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

"SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBUTION OPTION FOR HEALTH BENEFITS PLANS OF SMALL EMPLOYERS.

"(a) IN GENERAL.—For purposes of section 38, in the case of a small employer, the health benefits plan implementation credit determined under this section for the taxable year is an amount equal to 100 percent of the amount paid or incurred by the taxpayer during the taxable year for qualified health benefits expenses.

"(b) LIMITATION.—The credit determined under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the excess of—

"(1) $1,500, over

"(2) sum of the credits determined under subsection (a) with respect to such taxpayer for all preceding taxable years.

"(c) QUALIFIED HEALTH BENEFITS EXPENSES.—For purposes of this section, the term 'qualified health benefits auto-enrollment expenses' means, with respect to any taxable year, amounts paid or incurred by the taxpayer during such taxable year for—

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

surance coverage offered in connection with such a plan, and

''(2) implementing the employer contribution option for health insurance coverage pursuant to section 5000(e)(2).

''(d) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term 'qualified small employer' means any employer for any taxable year if the number of employees employed by such employer during such taxable year does not exceed 50. All employers treated as a single employer under section (a) or (b) of section 52 shall be treated as a single employer for purposes of this section.

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

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

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'' , and by adding at the end the following new paragraph:

''(36) in the case of a small employer (as defined in section 45R(d)), the health benefits plan implementation credit determined under section 45R(a).''.

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

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

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

SEC. 110. HSA MODIFICATIONS AND CLARIFICATIONS.

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

''(12) TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS.—Capitated primary care payments shall be treated as amounts paid for medical care.''.

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

amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR VETERANS OR INDIAN HEALTH BENEFITS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives periodic hospital care or medical services under any law administered by the Secretary of Veterans Affairs or the Bureau of Indian Affairs.''.

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

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

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

TITLE II—HEALTH INSURANCE POOLING MECHANISMS FOR INDIVIDUALS

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

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

No credit shall be allowed under section 36B of the Internal Revenue Code of 1986 (relating to health insurance costs of low-income individuals) to the residents of any State unless such State meets the following requirements:

(1) The State must implement a high-risk pool or a reinsurance pool or other risk-adjustment mechanism (as defined in section 211(h)).

(2) Assessments levied by the State for purposes of funding such a pool or mechanism must only be used for funding and administering such pool or mechanism.

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

Subtitle B—Federal Block Grants for State Insurance Expenditures

SEC. 211. FEDERAL BLOCK GRANTS FOR STATE INSURANCE EXPENDITURES.

(a) IN GENERAL.—Subject to the succeeding provisions of this section, each State shall receive from the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') a block grant for the State's providing for the use, in connection with providing health benefits coverage, of a qualifying high-risk pool or a reinsurance pool or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of private health insurance.

(b) FUNDING AMOUNT.—

(1) IN GENERAL.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $300,000,000 for fiscal year 2012 and each subsequent fiscal year for block grants under this section. Such amount shall be divided among the States as determined by the Secretary.

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

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

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

(1) QUALIFYING HIGH-RISK POOLS.—

(A) CURRENT POOLS.—A qualifying high-risk pool created before the date of the enactment of this Act that only cover high-risk populations and individuals (and their spouse and dependents) receiving a health care tax credit under section 35 of the Internal Revenue Code of 1986 for a limited period of time as determined by the Secretary or under section 2741 of Public Health Service Act.

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

(i) offers at least the option of one or more high-deductible plan options, in combination with a contribution into a health savings account;

(ii) offers multiple competing health plan options; and

(iii) covers only high-risk populations.

(2) RISK INSURANCE POOL OR OTHER RISK-ADJUSTMENT MECHANISMS.—

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

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

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

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

(1) Providing guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage under part B of title XXVII of the Public Health Service Act.

(2) A reduction in premium trends, actual premiums, or other cost-sharing requirements.

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

(4) States that adopt the Model Health Plan for Uninsurable Individuals Act of the National Association of Insurance Commissioners (if and when updated by such Association).

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

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

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

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

(h) REINSURANCE POOL OR OTHER RISK-ADJUSTMENT MECHANISM DEFINED.—For purposes of this section, the term ''reinsurance pool or other risk-adjustment mechanism'' means any State-based risk spreading mechanism to subsidize the purchase of private health insurance for the high-risk population.

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

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

(2) individuals who are provided health coverage by a high-risk pool.

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

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

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

Subtitle C—Health Care Access and Availability

SEC. 221. EXPANSION OF ACCESS AND CHOICE THROUGH INDIVIDUAL MEMBERSHIP ASSOCIATIONS (IMAS).

The Public Health Service Act, as amended by section 2, is further amended by inserting after title XXX the following new title:

''TITLE XXXI—INDIVIDUAL MEMBERSHIP ASSOCIATIONS

''SEC. 3101. DEFINITION OF INDIVIDUAL MEMBERSHIP ASSOCIATION (IMA).

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

''(1) ORGANIZATION.—The IMA is an organization operated under the direction of an association (as defined in section 3104(1)).

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) DIFFERENT GROUPS.—The IMA, in conjunction with those health insurance issuers that offer health benefits coverage through the IMA, makes available health benefits coverage in the manner described in subsection (b) to all members of the IMA and the dependents of such members in the manner described in subsection (c)(2) at rates that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law.

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

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

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

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

''(C) NO FINANCIAL UNDERWRITING.—The IMA provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

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

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The IMA may provide administrative services for members. Such services may include accounting, billing, and enrollment information.

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

''(5) FILING INFORMATION.—The IMA files with the Secretary information that demonstrates the IMA's compliance with the applicable requirements of this title.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through an IMA shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law,

''(ii) meets all applicable State standards relating to consumer protection, subject to section 3002(b), and

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law.

''(2) EXAMPLES OF TYPES OF COVERAGE.—The benefits coverage made available through an IMA may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

''(C) Coverage in connection with a licensed provider-sponsored organization.

''(D) Indemnity coverage through an insurance company.

''(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

''(F) Coverage that includes a point-of-service option.

''(G) Any combination of such types of coverage.

''(3) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through an IMA from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the IMA and comply with all other provisions of this title and

do not discriminate among similarly situated members.

''(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to an individual who is a member of an IMA, the individual may enroll for health benefits coverage (including coverage for dependents of such individual) offered by a health insurance issuer through the IMA.

''(B) RULES FOR ENROLLMENT.—Nothing in this paragraph shall preclude an IMA from establishing rules of enrollment and reenrollment of members. Such rules shall be applied consistently to all members within the IMA and shall not be based in any manner on health status-related factors.

''(2) HEALTH INSURANCE ISSUERS.—The contract between an IMA and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the IMA, for the payment of the premiums collected by the issuer.

"SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

"State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through an IMA:

"(1) Benefit requirements for health benefits coverage offered through an IMA, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

"(2) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through an IMA, if the IMA meets the requirements of this title.

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

"SEC. 3103. ADMINISTRATION.

"(a) IN GENERAL.—The Secretary shall administer this title and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The Secretary shall incorporate the process of 'deemed file and use' with respect to the information filed under section 3001(a)(5)(A) and shall determine whether information filed by an IMA demonstrates compliance with the applicable requirements of this title. The Secretary shall exercise authority under this title in a manner that fosters and promotes the development of IMAs in order to improve access to health care coverage and services.

"(b) PERIODIC REPORTS.—The Secretary shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the Secretary to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. The Secretary may provide for the production of such reports through one or more contracts with appropriate private entities.

"SEC. 3104. DEFINITIONS.

"For purposes of this title:

"(1) ASSOCIATION.—The term 'association' means, with respect to health insurance coverage offered in a State, a legal entity which—

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

"(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

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

"(D) does not make health insurance coverage offered through the association available other than in connection with a member of the association.

"(2) DEPENDENT.—The term 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meaning applied to such term with respect to such coverage under the laws of the State relating to such coverage and such an issuer. Such term may include the spouse and children of the individual involved.

''(3) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term health insurance coverage in section 2791(b)(1), and does not include excepted benefits (as defined in section 2791(c)).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2).

''(5) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIATION.—The terms 'IMA' and 'individual membership association' are defined in section 3101(a).

''(7) MEMBER.—The term 'member' means, with respect to an IMA, an individual who is a member of the association to which the IMA is offering coverage.''.

Subtitle D—Small Business Health Fairness

SEC. 231. SHORT TITLE.

This subtitle may be cited as the ''Small Business Health Fairness Act of 2011''.

SEC. 232. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a 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) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of

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

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

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

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to

the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

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

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

''(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

''(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food

service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

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

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

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

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

"(A) BOARD MEMBERSHIP.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

"(ii) LIMITATION.—

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

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

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON 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 an association

health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2011.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

"(1) each participating employer must be—

"(A) a member of the sponsor,

"(B) the sponsor, or

"(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

"(2) all individuals commencing coverage under the plan after certification under this part must be—

"(A) active or retired owners (including self-employed individuals), officers, directors, or

employees of, or partners in, participating employers; or

"(B) the beneficiaries of individuals described in subparagraph (A).

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2011, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

"(1) the affiliated member was an affiliated member on the date of certification under this part; or

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

"(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage

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

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

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

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

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

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in rela-

tion to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

''(i) setting contribution rates based on the claims experience of the plan; or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

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

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

"(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

"(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under section 731(a)(1) with respect to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

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

''(1) the benefits under the plan consist solely of health insurance coverage; or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

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

''(i) a reserve sufficient for unearned contributions;

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

''(iii) a reserve sufficient for any other obligations of the plan; and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified health actuary. The applicable

authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in clause (i), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified health actuary may recommend, taking into account the specific circumstances of the plan.

"(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

''(1) $500,000, or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, considering the level of aggregate and specific excess/stop loss insurance provided with respect to such plan and other factors related to solvency risk, such as the plan's projected levels of participation or claims, the nature of the plan's liabilities, and the types of assets available to assure that such liabilities are met.

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

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

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

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection

(a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

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

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on ac-

count of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

''(B) which is guaranteed renewable; and

"(C) which allows for payment of premiums by any third party on behalf of the insured plan.

"(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

"(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

"(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

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

"(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

''(A) A representative of the National Association of Insurance Commissioners.

''(B) A representative of the American Academy of Actuaries.

''(C) A representative of the State governments, or their interests.

''(D) A representative of existing self-insured arrangements, or their interests.

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

''(F) A representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

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

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the

120-day period ending with the date of the application, including the following:

"(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified health actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

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

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

tuarial opinion signed by a qualified health actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

"(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

"(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

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

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

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association 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.

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

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

''(f) ENGAGEMENT OF QUALIFIED HEALTH ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified health actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified health actuary under this part. The qualified health actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

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

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"Except as provided in section 809(b), an association 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;

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

"(3) submits such plan in writing to the applicable authority.

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

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than

health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified health actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective

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

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

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

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure

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

"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall

continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

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

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

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

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

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

''(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

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

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with

the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

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

''(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

"SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2011.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

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

or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

''(3) such tax is otherwise nondiscriminatory; and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

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

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary, except that, in connection with any exercise of the Secretary's authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

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

''(7) INDIVIDUAL MARKET.—

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

''(B) TREATMENT OF VERY SMALL GROUPS.—

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

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee,

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

''(9) 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 designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED HEALTH ACTUARY.—The term 'qualified health actuary' means an individual who is a member of the American Academy of Actuaries with expertise in health care.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

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

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

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6))

includes any partner in relation to the partnership; and

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

"(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.

"(3) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to a group health plan in relation to its provision of excepted benefits, as defined in section 706(c).".

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

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

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

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

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as de-

fined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

''(A) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

''(B) relating to prompt payment of claims.

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

''(5) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have

the meanings provided such terms in section 812, respectively.''.

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

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

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

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

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

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2011 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

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

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

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

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

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

SEC. 233. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after ''control group,'' the following: ''except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,'';

(2) in clause (iii), by striking ''(iii) the determination'' and inserting the following:

''(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under regulations of the Secretary applying principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, an interest of greater than 25 percent may

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

''(II) in any other case, the determination'';

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

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

''(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 234. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

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

Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''Sec. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

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

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement described in section 3(40)(A)(i),

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

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

''(n) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

''(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

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

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

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

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

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

''(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 235. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

''(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and

''(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 236. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within 1 year after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

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

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

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

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

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

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(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

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

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

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

"(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1), but does not include excepted benefits described in section 2791(c).

"(5) 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 designated by the State to enforce the requirements of this title for the State with respect to the issuer.

"(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

"(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

"(B) to pay other obligations in the normal course of business.

"(7) COVERED LAWS.—

"(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agree-

ments, and orders governing the insurance business pertaining to—

"(i) individual health insurance coverage issued by a health insurance issuer;

"(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

"(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

"(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

"(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

"(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or

order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

''(8) STATE.—The term 'State' means only the 50 States and the District of Columbia.

''(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

''(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

''(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

''(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

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

''(E) Refusing to pay claims without conducting a reasonable investigation.

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

"(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

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

"(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

"(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests 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.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

''(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

''SEC. 2796. APPLICATION OF LAW.

''(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the 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

''(ii) any such examination is conducted in accordance with the examiners'

handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

''(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

''(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section

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

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

''(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

''(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

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

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

State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.

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

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

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

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

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

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

''(B) from raising premium rates for all policy holders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

''(iii) are not obtainable by all individuals to whom coverage is offered;

''(D) from reinstating lapsed coverage; or

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

''(e) PRIOR OFFERING OF POLICY IN PRIMARY 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 qualifica-

tion or requirement which discriminates against a non-resident 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 shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent

public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

"(A) a member of the American Academy of Actuaries; or

"(B) a qualified loss reserve specialist.

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

"(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

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

"(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

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

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

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

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

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

''SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

''A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

''SEC. 2798. LIMITATION ON INDIVIDUAL PURCHASE IN SECONDARY STATE.

''Effective beginning two years after the date of enactment of this part, an individual in a State may not buy individual health insurance coverage in a secondary State if the premium for individual health insurance in the primary State (with respect to the individual) exceeds the national average premium by 10 percent or more.

"SEC. 2799. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

"(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

"(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

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

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

''(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

''(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

''(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

''(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in one or more States to deliver health care services; and

''(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

''(I) a non-affiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

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

"(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

"(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

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

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

''(A) not exceed a reasonable level; and

''(B) not be contingent on the decision rendered by the reviewer.

''(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

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

''(B) The enrollee (or authorized representative).

"(C) The health care professional that provides the items or services involved in the denial.

"(D) The institution at which the items or services (or treatment) involved in the denial are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

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

"(8) DEFINITIONS.—For purposes of this subsection:

"(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.

"(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 services and who is operating within the scope of such licensure, accreditation, or certification.

"SEC. 2800. ENFORCEMENT.

"(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

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

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

"(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.".

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

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

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

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

(d) SEVERABILITY.—If any provision of the section or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder

of this section and the application of the provisions of such to any other person or circumstance shall not be affected.

TITLE IV—SAFETY NET REFORMS

SEC. 401. REQUIRING OUTREACH AND COVERAGE BEFORE EXPANSION OF ELIGIBILITY.

(a) STATE CHILD HEALTH PLAN REQUIRED TO SPECIFY HOW IT WILL ACHIEVE COVERAGE FOR 90 PERCENT OF TARGETED LOW-INCOME CHILDREN.—

(1) IN GENERAL.—Section 2102(a) of the Social Security Act (42 U.S.C. 1397bb(a)) is amended—

(A) in paragraph (6), by striking ''and'' at the end;

(B) in paragraph (7), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(8) how the eligibility and benefits provided for under the plan for each fiscal year (beginning with fiscal year 2013) will allow for the State's annual funding allotment to cover at least 90 percent of the eligible targeted low-income children in the State.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to State child health plans for fiscal years beginning with fiscal year 2013.

(b) LIMITATION ON PROGRAM EXPANSIONS UNTIL LOWEST INCOME ELIGIBLE INDIVIDUALS ENROLLED.—Section 2105(c) of such Act (42 U.S.C. 1397dd(c)) is amended by adding at the end the following new paragraph:

"(12) LIMITATION ON INCREASED COVERAGE OF HIGHER INCOME CHILDREN.—

"(A) IN GENERAL.—For child health assistance furnished in a fiscal year beginning with fiscal year 2013:

"(i) NO PAYMENT FOR CHILDREN WITH FAMILY INCOME ABOVE 300 PERCENT OF POVERTY LINE.—Payment shall not be made under this section for child health assistance for a targeted low-income child in a family the income of which exceeds 300 percent of the poverty line applicable to a family of the size involved.

"(ii) SPECIAL RULES FOR PAYMENT FOR CHILDREN WITH FAMILY INCOME ABOVE 200 PERCENT OF POVERTY LINE.—

In the case of child health assistance for a targeted low-income child in a family the income of which exceeds 200 percent (but does not exceed 300 percent) of the poverty line applicable to a family of the size involved no payment shall be made under this section for such assistance unless the State demonstrates to the satisfaction of the Secretary that—

"(I) the State has met the 90 percent retrospective coverage test specified in subparagraph (B)(i) for the previous fiscal year; and

"(II) the State will meet the 90 percent prospective coverage test specified in subparagraph (B)(ii) for the fiscal year.

"(B) 90 PERCENT COVERAGE TESTS.—

"(i) RETROSPECTIVE TEST.—The 90 percent retrospective coverage test specified in this clause is, for a State for a fiscal year, that on average during the fiscal year, the State has enrolled under this title or title XIX at least 90 percent of the individuals residing in the State who—

"(I) are children under 19 years of age (or are pregnant women) and are eligible for medical assistance under title XIX; or

"(II) are targeted low-income children whose family income does not exceed 200 percent of the poverty line and who are eligible for child health assistance under this title.

"(ii) PROSPECTIVE TEST.—The 90 percent prospective test specified in this clause is, for a State for a fiscal year, that on average during the fiscal year, the State will enroll under this title or title XIX at least 90 percent of the individuals residing in the State who—

"(I) are children under 19 years of age (or are pregnant women) and are eligible for medical assistance under title XIX; or

"(II) are targeted low-income children whose family income does not exceed such percent of the poverty line (in excess of 200 percent) as the State elects consistent with this para-

graph and who are eligible for child health assistance under this title.

''(C) GRANDFATHER.—Clauses (i) and (ii) of subparagraph (A) shall not apply to the provision of child health assistance—

''(i) to a targeted low-income child who is enrolled for child health assistance under this title as of September 30, 2010;

''(ii) to a pregnant woman who is enrolled for assistance under this title as of September 30, 2011, through the completion of the post-partum period following completion of her pregnancy; and

''(iii) for items and services furnished before October 1, 2012, to an individual who is not a targeted low-income child and who is enrolled for assistance under this title as of September 30, 2011.

''(D) TREATMENT OF PREGNANT WOMEN.—In this paragraph and sections 2102(a)(8) and 2104(a)(2), the term 'targeted low-income child' includes an individual under age 19, including the period from conception to birth, who is eligible for child health assistance under this title by virtue of the definition of the

term 'child' under section 457.10 of title 42, Code of Federal Regulations.''.

(c) STANDARDIZATION OF INCOME DETERMINATIONS.—

(1) IN GENERAL.—Section 2110(d) of such Act (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF INCOME DETERMINATIONS.—In determining family income under this title (including in the case of a State child health plan that provides health benefits coverage in the manner described in section 2101(a)(2)), a State shall base such determination on gross income (including amounts that would be included in gross income if they were not exempt from income taxation) and may only take into consideration such income disregards as the Secretary shall develop.''.

(2) EFFECTIVE DATE.—(A) Subject to subparagraph (B), the amendment made by paragraph (1) shall apply to determinations (and redeterminations) of income made on or after April 1, 2012.

(B) In the case of a State child health plan under title XXI of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the

additional requirement imposed by the amendment made by paragraph (1), the State child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 402. EASING ADMINISTRATIVE BARRIERS TO STATE COOPERATION WITH EMPLOYER-SPONSORED INSURANCE COVERAGE.

(a) REQUIRING SOME COVERAGE FOR EMPLOYER-SPONSORED INSURANCE UNDER CHIP.—Section 2102(a) of the Social Security Act (42 U.S.C. 1397b(a)), as amended by section 401(a), is amended—

(1) in paragraph (7), by striking ''and'' at the end;

(2) in paragraph (8), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(9) effective for plan years beginning on or after October 1, 2012, how the plan will provide for child health assistance with respect to targeted low-income children covered under a group health plan.''.

(b) FEDERAL FINANCIAL PARTICIPATION FOR EMPLOYER-SPONSORED INSURANCE.—Section 2105 of such Act (42 U.S.C. 1397d) is amended—

(1) in subsection (a)(1)(C), by inserting before the semicolon at the end the following: ''and, subject to paragraph (3)(C), in the form of payment of the premiums for coverage under a group health plan that includes coverage of targeted low-income children and benefits supplemental to such coverage''; and

(2) by amending paragraph (3) of subsection (c) to read as follows:

''(3) PURCHASE OF EMPLOYER-SPONSORED INSURANCE.—

''(A) IN GENERAL.—Payment may be made to a State under subsection (a)(1)(C), subject to the provisions of this paragraph, for the purchase of family coverage under a group

health plan that includes coverage of targeted low-income children unless such coverage would otherwise substitute for coverage that would be provided to such children but for the purchase of family coverage.

''(B) WAIVER OF CERTAIN PROVISIONS.—With respect to coverage described in subparagraph (A)—

''(i) notwithstanding section 2102, no minimum benefits requirement (other than those otherwise applicable with respect to services referred to in section 2102(a)(7)) under this title shall apply; and

''(ii) no limitation on beneficiary cost-sharing otherwise applicable under this title or title XIX shall apply.

''(C) REQUIRED PROVISION OF SUPPLEMENTAL BENEFITS.—If the coverage described in subparagraph (A) does not provide coverage for the services referred to in section 2102(a)(7), the State child health plan shall provide coverage of such services as supplemental benefits.

''(D) LIMITATION ON FFP.—The amount of the payment under paragraph (1)(C) for cov-

erage described in subparagraph (A) (and supplemental benefits under subparagraph (C) for individuals so covered) during a fiscal year may not exceed the product of—

"(i) the national per capita expenditure under this title (taking into account both Federal and State expenditures) for the previous fiscal year (as determined by the Secretary using the best available data);

"(ii) the enhanced FMAP for the State and fiscal year involved; and

"(iii) the number of targeted low-income children for whom such coverage is provided.

"(E) VOLUNTARY ENROLLMENT.—A State child health plan—

"(i) may not require a targeted low-income child to enroll in coverage described in subparagraph (A) in order to obtain child health assistance under this title;

"(ii) before providing such child health assistance for such coverage of a child, shall make available (which may be through an Internet Web site or other

means including the State transparency plan portal established under section 901 of the Empowering Patients First Act) to the parent or guardian of the child information on the coverage available under this title, including benefits and cost-sharing; and

''(iii) shall provide at least one opportunity per fiscal year for beneficiaries to switch coverage under this title from coverage described in subparagraph (A) to the coverage that is otherwise made available under this title.

''(F) INFORMATION ON COVERAGE OPTIONS.—A State child health plan shall—

''(i) describe how the State will notify potential beneficiaries of coverage described in subparagraph (A);

''(ii) provide such notification in writing at least during the initial application for enrollment under this title and during redeterminations of eligibility if the individual was enrolled before October 1, 2012; and

"(iii) post a description of these coverage options on any official Web site that may be established by the State in connection with the plan, including the State transparency plan portal established under section 901 of the Empowering Patients First Act.

"(G) SEMIANNUAL VERIFICATION OF COVERAGE.—If coverage described in subparagraph (A) is provided under a group health plan with respect to a targeted low-income child, the State child health plan shall provide for the collection, at least once every six months, of proof from the plan that the child is enrolled in such coverage.

"(H) RULE OF CONSTRUCTION.—Nothing in this section is to be construed to prohibit a State from—

"(i) offering wrap around benefits in order for a group health plan to meet any State-established minimum benefit requirements;

"(ii) establishing a cost-effectiveness test to qualify for coverage under such a plan;

"(iii) establishing limits on beneficiary cost-sharing under such a plan;

"(iv) paying all or part of a beneficiary's cost-sharing requirements under such a plan;

"(v) paying less than the full cost of the employee's share of the premium under such a plan, including prorating the cost of the premium to pay for only what the State determines is the portion of the premium that covers targeted low-income children;

"(vi) using State funds to pay for benefits above the Federal upper limit established under subparagraph (C);

"(vii) allowing beneficiaries enrolled in group health plans from changing plans to another coverage option available under this title at any time; or

"(viii) providing any guidance or information it deems appropriate in order to help beneficiaries make an informed decision regarding the option to enroll in coverage described in subparagraph (A).

''(I) GROUP HEALTH PLAN DEFINED.—In this paragraph, the term 'group health plan' has the meaning given such term in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)).''.

(c) APPLICATION UNDER MEDICAID.—The Secretary of Health and Human Services shall provide for the application of the amendments made by subsections (a) and (b) under the Medicaid program under title XIX of the Social Security Act in the same manner as such amendments apply to SCHIP under title XXI of such Act.

SEC. 403. IMPROVING BENEFICIARY CHOICE IN SCHIP.

(a) REQUIRING OFFERING OF ALTERNATIVE COVERAGE OPTIONS.—Section 2102 of the Social Security Act (42 U.S.C. 1397b), as amended by sections 401(a) and 402(a), is amended—

(1) in subsection (a)—

(A) in paragraph (8), by striking ''and'' at the end;

(B) in paragraph (9), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(10) effective for plan years beginning on or after October 1, 2012, how the plan will provide for

child health assistance with respect to targeted low-income children through alternative coverage options in accordance with subsection (e).''; and

(2) by adding at the end the following new subsection:

''(d) ALTERNATIVE COVERAGE OPTIONS.—

''(1) IN GENERAL.—Effective October 1, 2012, a State child health plan shall provide for the offering of any qualified alternative coverage that a qualified entity seeks to offer to targeted low-income children through the plan in the State.

''(2) APPLICATION OF UNIFORM FINANCIAL LIMITATION FOR ALL ALTERNATIVE COVERAGE OPTIONS.—With respect to all qualified alternative coverage offered in a State, the State child health plan shall establish a uniform dollar limitation on the per capita monthly amount that will be paid by the State to the qualified entity with respect to such coverage provided to a targeted low-income child. Such limitation may not be less than 90 percent of the per capita monthly payment made for coverage offered under the State child health plan that is not in the form of an alternative coverage option. Nothing in this paragraph shall be construed—

"(A) as requiring a State to provide for the full payment of premiums for qualified alternative coverage;

"(B) as preventing a State from charging additional premiums to cover the difference between the cost of qualified alternative coverage and the amount of such payment limitation; or

"(C) as preventing a State from using its own funds to provide a dollar limitation that exceeds the Federal financial participation as limited under section 2105(c)(10).

"(3) TREATMENT OF LOW COST COVERAGE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if the uniform dollar limitation under paragraph (2) exceeds the premium for qualified alternative coverage for an enrollee, then such excess shall be refunded to the Federal and State governments in the same proportion as is otherwise applicable to recovered funds under this title.

"(B) EXCEPTION FOR HIGH-DEDUCTIBLE HEALTH PLANS.—In the case of coverage under a high-deductible health plan, the excess described in subparagraph (A) shall be deposited

into a health savings account established with respect to such plan.

''(4) EXEMPTION.—A State is not subject to the requirement of paragraph (1) if the State child health plan provides, as of the date of the enactment of this subsection, for a cash out or health savings account type option for those enrolled under the plan.

''(5) QUALIFIED ALTERNATIVE COVERAGE DEFINED.—In this section, the term 'qualified alternative coverage' means health insurance coverage that—

''(A) meets the coverage requirements of section 2103 (other than cost-sharing requirements of such section); and

''(B) is offered by a qualified insurer, and not directly by the State.

''(6) QUALIFIED INSURER DEFINED.—In this section, the term 'qualified insurer' means, with respect to a State, an entity that is licensed to offer health insurance coverage in the State.''.

(b) FEDERAL FINANCIAL PARTICIPATION FOR QUALIFIED ALTERNATIVE COVERAGE.—Section 2105 of such Act (42 U.S.C. 1397d) is amended—

(1) in subsection (a)(1)(C), as amended by section 402(b), by inserting before the semicolon at the end the following: ''and, subject to paragraph (13)(C), in the form of payment of the premiums for coverage for qualified alternative coverage''; and

(2) in subsection (c), as amended by section 401(b) by adding at the end the following new paragraph:

''(13) PURCHASE OF QUALIFIED ALTERNATIVE COVERAGE.—

''(A) IN GENERAL.—Payment may be made to a State under subsection (a)(1)(C), subject to the provisions of this paragraph, for the purchase of qualified alternative coverage.

''(B) WAIVER OF CERTAIN PROVISIONS.—With respect to coverage described in subparagraph (A), no limitation on beneficiary cost-sharing otherwise applicable under this title or title XIX shall apply.

''(C) LIMITATION ON FFP.—The amount of the payment under paragraph (1)(C) for coverage described in subparagraph (A) during a fiscal year in the aggregate for all such coverage in the State may not exceed the product of—

"(i) the national per capita expenditure under this title (taking into account both Federal and State expenditures) for the previous fiscal year (as determined by the Secretary using the best available data);

"(ii) the enhanced FMAP for the State and fiscal year involved; and

"(iii) the number of targeted low-income children for whom such coverage is provided.

"(D) VOLUNTARY ENROLLMENT.—A State child health plan—

"(i) may not require a targeted low-income child to enroll in coverage described in subparagraph (A) in order to obtain child health assistance under this title;

"(ii) before providing such child health assistance for such coverage of a child, shall make available (which may be through an Internet Web site or other means) to the parent or guardian of the child information on the coverage available under this title, including benefits and cost-sharing; and

"(iii) shall provide at least one opportunity per fiscal year for beneficiaries to switch coverage under this title from coverage described in subparagraph (A) to the coverage that is otherwise made available under this title.

"(E) INFORMATION ON COVERAGE OPTIONS.—A State child health plan shall—

"(i) describe how the State will notify potential beneficiaries of coverage described in subparagraph (A);

"(ii) provide such notification in writing at least during the initial application for enrollment under this title and during redeterminations of eligibility if the individual was enrolled before October 1, 2012; and

"(iii) post a description of these coverage options on any official Web site that may be established by the State in connection with the plan.

"(F) RULE OF CONSTRUCTION.—Nothing in this section is to be construed to prohibit a State from—

"(i) establishing limits on beneficiary cost-sharing under such alternative coverage;

"(ii) paying all or part of a beneficiary's cost-sharing requirements under such coverage;

"(iii) paying less than the full cost of a child's share of the premium under such coverage, insofar as the premium for such coverage exceeds the limitation established by the State under subparagraph (C);

"(iv) using State funds to pay for benefits above the Federal upper limit established under subparagraph (C); or

"(v) providing any guidance or information it deems appropriate in order to help beneficiaries make an informed decision regarding the option to enroll in coverage described in subparagraph (A).".

(c) APPLICATION UNDER MEDICAID.—The Secretary of Health and Human Services shall provide for the application of the amendments made by subsections (a) and (b) under the Medicaid program under title XIX of the Social Security Act in the same manner as such amendments apply to SCHIP under title XXI of such Act.

TITLE V—MEDICAL LIABILITY REFORMS

SEC. 501. SHORT TITLE.

This title may be cited as the ''Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011''.

SEC. 502. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to

the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 503. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 504. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought

or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of

this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 505. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) Forty percent of the first $50,000 recovered by the claimant(s).

(2) Thirty-three and one-third percent of the next $50,000 recovered by the claimant(s).

(3) Twenty-five percent of the next $500,000 recovered by the claimant(s).

(4) Fifteen percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 506. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled

as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 507. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the re-

quest of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as

the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

(c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Serv-

ices (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

(4) EXCEPTION.—Paragraph (1) shall not apply in any health care lawsuit in which—

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is causally related to the harm which the claimant allegedly suffered;

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product; or

(C) the defendant caused the medical product which caused the claimant's harm to be misbranded or adulterated (as such terms are used in chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.)).

SEC. 508. LIMITATION ON RECOVERY IN A HEALTH CARE LAWSUIT BASED ON COMPLIANCE WITH BEST PRACTICE GUIDELINES.

(a) SELECTION AND ISSUANCE OF BEST PRACTICES GUIDELINES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide for the selection and issuance of best practice guidelines for treatment of medical conditions (each in this subsection referred to as a ''guideline'') in accordance with paragraphs (2) and (3).

(2) DEVELOPMENT PROCESS.—Not later than 90 days after the date of enactment of this title, the Secretary shall enter into a contract with a qualified physician consensus-building organization (such as the Physician Consortium for Performance Improvement), in concert and agreement with physician specialty organizations, to develop guidelines. The contract shall require that the organization submit

guidelines to the agency not later than 18 months after the date of enactment of this title.

(3) ISSUANCE.—

(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this title, the Secretary shall, after notice and opportunity for public comment, make a rule that provides for the establishment of the guidelines submitted under paragraph (2).

(B) LIMITATION.—The Secretary may not make a rule that includes guidelines other than those submitted under paragraph (2).

(C) DISSEMINATION.—The Secretary shall post such guidelines on the public Internet web page of the Department of Health and Human Services.

(4) MAINTENANCE.—Not later than 4 years after the date of enactment of this title, and every 2 years thereafter, the Secretary shall review the guidelines and shall, as necessary, enter into contracts similar to the contract described in paragraph (2), and issue guidelines in a manner similar to the issuance of guidelines under paragraph (3).

(b) LIMITATION ON DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—In any health care lawsuit, a court may not award noneconomic damages with respect to treatment that is consistent with a guideline issued under subsection (a).

(2) LIMITATION ON PUNITIVE DAMAGES.—In any health care lawsuit, no punitive damages may be awarded against a health care provider based on a claim that such treatment caused the claimant harm if—

(A) such treatment was subject to quality review by a qualified physician consensus-building organization and has been found to be safe, effective, and appropriate;

(B) such treatment was approved in a guideline that underwent full review by such organization, public comment, approval by the Secretary, and dissemination as described in subparagraph (a); or

(C) such medical treatment is generally recognized among qualified experts (including medical providers and relevant physician specialty organizations) as safe, effective, and appropriate.

(c) USE.—

(1) INTRODUCTION AS EVIDENCE.—Guidelines established in a rule made under subsection (a) may not be introduced as evidence of negligence or deviation in the standard of care in any health care lawsuit unless they have previously been introduced by the defendant.

(2) NO PRESUMPTION OF NEGLIGENCE.—There shall be no presumption of negligence if a health care provider provides treatment in a manner inconsistent with such guidelines.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(1) replacing their current medical malpractice rules with rules that rely, as a defense, upon a health care provider's compliance with a guideline issued under subsection (a); or

(2) applying additional guidelines or safe-harbors that are in addition to, but not in lieu of, the guidelines issued under subsection (a).

SEC. 509. STATE GRANTS TO CREATE ADMINISTRATIVE HEALTH CARE TRIBUNALS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399T. STATE GRANTS TO CREATE ADMINISTRATIVE HEALTH CARE TRIBUNALS.

"(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of administrative health care tribunals that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers.

"(b) CONDITIONS FOR DEMONSTRATION GRANTS.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

"(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute before an administrative health care tribunal operated under such grant from obtaining legal representation during any review by the expert panel under subsection (d), the administrative health care tribunal under subsection (e), or a State court under subsection (f).

"(d) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

"(1) IN GENERAL.—Prior to the submission of any dispute concerning injuries allegedly caused by

health care providers to an administrative health care tribunal under this section, such allegations shall first be reviewed by an expert panel.

''(2) COMPOSITION.—

''(A) IN GENERAL.—The members of each expert panel under this subsection shall be appointed by the head of the State agency responsible for health. Each expert panel shall be composed of no fewer than 3 members and not more than 7 members. At least one-half of such members shall be medical experts (either physicians or health care professionals).

''(B) LICENSURE AND EXPERTISE.—Each physician or health care professional appointed to an expert panel under subparagraph (A) shall—

''(i) be appropriately credentialed or licensed in one or more States to deliver health care services; and

''(ii) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

''(C) INDEPENDENCE.—

"(i) IN GENERAL.—Subject to clause (ii), each individual appointed to an expert panel under this paragraph shall—

"(I) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

"(II) not otherwise have a conflict of interest with such a party.

"(ii) EXCEPTION.—Nothing in clause (i) shall be construed to prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

"(D) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

"(i) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

"(I) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(II) by a health care professional other than a physician, at least two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, an additional medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

"(ii) PRACTICING DEFINED.—In this paragraph, the term 'practicing' means,

with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

''(E) PEDIATRIC EXPERTISE.—In the case of dispute relating to a child, at least 1 medical expert on the expert panel shall have expertise described in subparagraph (D)(i) in pediatrics.

''(3) DETERMINATION.—After a review under paragraph (1), an expert panel shall make a determination as to the liability of the parties involved and compensation.

''(4) ACCEPTANCE.—If the parties to a dispute before an expert panel under this subsection accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers involved.

''(5) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel's determination, the matter shall be referred to an administrative health care tribunal created pursuant to this section.

''(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(1) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subsection (d), the parties shall have the right to request a hearing concerning the liability or compensation involved by an administrative health care tribunal established by the State involved.

''(2) REQUIREMENTS.—In establishing an administrative health care tribunal under this section, a State shall—

''(A) ensure that such tribunals are presided over by special judges with health care expertise;

''(B) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

''(C) establish gross negligence as the legal standard for the tribunal;

''(D) allow the admission into evidence of the recommendation made by the expert panel under subsection (d); and

''(E) provide for an appeals process to allow for review of decisions by State courts.

''(f) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(1) RIGHT TO FILE.—If any party to a dispute before a health care tribunal under subsection (e) is not satisfied with the determinations of the tribunal, the party shall have the right to file their claim in a State court of competent jurisdiction.

''(2) FORFEIT OF AWARDS.—Any party filing an action in a State court in accordance with paragraph (1) shall forfeit any compensation award made under subsection (e).

''(3) ADMISSIBILITY.—The determinations of the expert panel and the administrative health care tribunal pursuant to subsections (d) and (e) with respect to a State court proceeding under paragraph (1) shall be admissible into evidence in any such State court proceeding.

''(g) DEFINITION.—In this section, the term 'health care provider' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such

sums as may be necessary for purposes of making grants to States under this section.''.

SEC. 510. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments, in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 511. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a man-

ner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and non-

economic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) FEDERAL TAX BENEFIT.—A claimant shall be treated as receiving a Federal tax benefit with respect to payment for items or services if—

(A) such payment is compensation by insurance—

(i) which constitutes medical care, and

(ii) with respect to the payment of premiums for which the claimant, or the employer of the claimant, was allowed an exclusion from gross income, a deduction,

or a credit for Federal income tax purposes,

(B) a deduction was allowed with respect to such payment for Federal income tax purposes, or

(C) such payment was from an Archer MSA (as defined in section 220(d) of the Internal Revenue Code of 1986), a health savings account (as defined in section 223(d) of such Code), a flexible spending arrangement (as defined in section 106(c)(2) of such Code), or a health reimbursement arrangement which is treated as employer-provided coverage under an accident or health plan for purposes of section 106 of such Code.

(8) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services brought in a Federal court or in a State court or pursuant to an alternative dispute resolution system, if such claim concerns items or services with respect to which payment is made under title XVIII, title XIX, or title XXI of the Social Security Act or for which the claimant receives a Federal tax benefit, against a health care provider, a health care

organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal government; or which is grounded in antitrust.

(9) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR,

against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(11) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(13) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(14) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(15) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(16) MEDICAL TREATMENT.—The term ''medical treatment'' means the provision of any goods or

services by a health care provider or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(17) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation, and any other nonpecuniary losses.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(19) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecu-

tion or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(20) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 512. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to

which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 513. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This title shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this title or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this title shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this title) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 4(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 514. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this title, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

TITLE VI—WELLNESS AND PREVENTION

SEC. 601. PROVIDING FINANCIAL INCENTIVES FOR TREATMENT COMPLIANCE.

(a) LIMITATION ON EXCEPTION FOR WELLNESS PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

(1) ERISA AMENDMENT.—Section 702(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)(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 (or lack of participation) in a standards-based wellness program.''.

(2) PHSA AMENDMENT.—Section 2702(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(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 (or lack of participation) in a standards-based wellness program.''.

(3) IRC AMENDMENT.—Section 9802(b)(2) of the Internal Revenue Code of 1986 is amended by adding after and below subparagraph (B) the following:

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

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

TITLE VII—TRANSPARENCY AND INSURANCE REFORM MEASURES

SEC. 701. RECEIPT AND RESPONSE TO REQUESTS FOR CLAIM INFORMATION.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

"SEC. 2714. RECEIPT AND RESPONSE TO REQUESTS FOR CLAIM INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—In the case of health insurance coverage offered in connection with a group health plan, not later than the 30th day after the date a health insurance issuer receives a written request for a written report of claim information from the plan, plan sponsor, or plan administrator, the health insurance issuer shall provide the requesting party the report, subject to the succeeding provisions of this section.

''(2) EXCEPTION.—The health insurance issuer is not obligated to provide a report under this subsection regarding a particular employer or group

health plan more than twice in any 12-month period and is not obligated to provide such a report in the case of an employer with fewer than 50 employees.

''(3) DEADLINE.—A plan, plan sponsor, or plan administrator must request a report under this subsection before or on the second anniversary of the date of termination of coverage under a group health plan issued by the health insurance issuer.

''(b) FORM OF REPORT; INFORMATION TO BE INCLUDED.—

''(1) IN GENERAL.—A health insurance issuer shall provide the report of claim information under subsection (a)—

''(A) in a written report;

''(B) through an electronic file transmitted by secure electronic mail or a file transfer protocol site; or

''(C) by making the required information available through a secure Web site or Web portal accessible by the requesting plan, plan sponsor, or plan administrator.

''(2) INFORMATION TO BE INCLUDED.—A report of claim information provided under subsection (a) shall contain all information available to the health insurance issuer that is responsive to the re-

quest made under such subsection, including, subject to subsection (c), protected health information, for the 36-month period preceding the date of the report or the period specified by subparagraphs (D), (E), and (F) of paragraph (3), if applicable, or for the entire period of coverage, whichever period is shorter.

''(3) REQUIRED INFORMATION.—Subject to subsection (c), a report provided under subsection (a) shall include the following:

''(A) Aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable.

''(B) Total premium paid by month.

''(C) Total number of covered employees on a monthly basis by coverage tier, including whether coverage was for—

''(i) an employee only;

''(ii) an employee with dependents only;

''(iii) an employee with a spouse only; or

''(iv) an employee with a spouse and dependents.

''(D) The total dollar amount of claims pending as of the date of the report.

''(E) A separate description and individual claims report for any individual whose total paid claims exceed $15,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual—

''(i) a unique identifying number, characteristic, or code for the individual;

''(ii) the amounts paid;

''(iii) dates of service; and

''(iv) applicable procedure codes and diagnosis codes.

''(F) For claims that are not part of the information described in a previous subparagraph, a statement describing precertification requests for hospital stays of 5 days or longer that were made during the 30-day period preceding the date of the report.

''(c) LIMITATIONS ON DISCLOSURE.—

''(1) IN GENERAL.—A health insurance issuer may not disclose protected health information in a report of claim information provided under this section if the health insurance issuer is prohibited from

disclosing that information under another State or Federal law that imposes more stringent privacy restrictions than those imposed under Federal law under the HIPAA privacy regulations. To withhold information in accordance with this subsection, the health insurance issuer must—

''(A) notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld; and

''(B) provide to the plan, plan sponsor, or plan administrator a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another State or Federal law.

''(2) PROTECTION.—A plan sponsor is entitled to receive protected health information under subparagraph (E) and (F) of subsection (b)(3) and subsection (d) only after an appropriately authorized representative of the plan sponsor makes to the health insurance issuer a certification substantially similar to the following certification: 'I hereby certify that the plan documents comply with the requirements of section 164.504(f)(2) of title 45, Code of Federal Regulations, and that the plan sponsor will

safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions.'.

''(3) RESULTS.—A plan sponsor that does not provide the certification required by paragraph (2) is not entitled to receive the protected health information described by subparagraphs (E) and (F) of subsection (b)(3) and subsection (d), but is entitled to receive a report of claim information that includes the information described by subparagraphs (A) through (D) of subsection (b)(3).

''(4) INFORMATION.—In the case of a request made under subsection (a) after the date of termination of coverage, the report must contain all information available to the health insurance issuer as of the date of the report that is responsive to the request, including protected health information, and including the information described by subsection (b)(3), for the period described by subsection (b)(2) preceding the date of termination of coverage or for the entire policy period, whichever period is shorter. Notwithstanding this subsection, the report may not include the protected health information described by subparagraphs (E) and (F) of subsection (b)(3)

unless a certification has been provided in accordance with paragraph (2).

''(d) REQUEST FOR ADDITIONAL INFORMATION.—

''(1) REVIEW.—On receipt of the report required by subsection (a), the plan, plan sponsor, or plan administrator may review the report and, not later than the 10th day after the date the report is received, may make a written request to the health insurance issuer for additional information in accordance with this subsection for specified individuals.

''(2) REQUEST.—With respect to a request for additional information concerning specified individuals for whom claims information has been provided under subsection (b)(3)(E), the health insurance issuer shall provide additional information on the prognosis or recovery if available and, for individuals in active case management, the most recent case management information, including any future expected costs and treatment plan, that relate to the claims for that individual.

''(3) RESPONSE.—The health insurance issuer must respond to the request for additional information under this subsection not later than the 15th day after the date of such request unless the re-

questing plan, plan sponsor, or plan administrator agrees to a request for additional time.

''(4) LIMITATION.—The health insurance issuer is not required to produce the report described by this subsection unless a certification has been provided in accordance with subsection (c)(2).

''(5) COMPLIANCE WITH SECTION DOES NOT CREATE LIABILITY.—A health insurance issuer that releases information, including protected health information, in accordance with this subsection has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.

''(e) LIMITATION ON PREEMPTION.—Nothing in this section is meant to limit States from enacting additional laws in addition to the provisions of this section, but not in lieu of such provisions.

''(f) DEFINITIONS.—In this section:

''(1) The terms 'employer', 'plan administrator', and 'plan sponsor' have the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

''(2) The term 'HIPAA privacy regulations' has the meaning given such term in section 1180(b)(3) of the Social Security Act.

''(3) The term 'protected health information' has the meaning given such term under the HIPAA privacy regulations.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

TITLE VIII—QUALITY

SEC. 801. PROHIBITION ON CERTAIN USES OF DATA OBTAINED FROM COMPARATIVE EFFECTIVENESS RESEARCH; ACCOUNTING FOR PERSONALIZED MEDICINE AND DIFFERENCES IN PATIENT TREATMENT RESPONSE.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services—

(1) shall not use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))); and

(2) shall ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient-reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

(b) CONSULTATION AND APPROVAL REQUIRED.—Nothing the Federal Coordinating Council for Comparative Effectiveness Research finds can be released in final form until after consultation with and approved by relevant physician specialty organizations.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

SEC. 802. ESTABLISHMENT OF PERFORMANCE-BASED QUALITY MEASURES.

Not later than January 1, 2012, the Secretary of Health and Human Services shall submit to Congress a proposal for a formalized process for the development of performance-based quality measures that could be applied to physicians' services under the Medicare program under

title XVIII of the Social Security Act. Such proposal shall be in concert and agreement with the Physician Consortium for Performance Improvement and shall only utilize measures agreed upon by each physician specialty organization.

TITLE IX—STATE TRANSPARENCY PLAN PORTAL

SEC. 901. PROVIDING INFORMATION ON HEALTH COVERAGE OPTIONS AND HEALTH CARE PROVIDERS.

(a) STATE-BASED PORTAL.—A State (by itself or jointly with other States) may contract with a private entity to establish a Health Plan and Provider Portal Web site (referred to in this section as a ''plan portal'') for the purposes of providing standardized information—

(1) on health insurance plans that have been certified to be available for purchase in that State; and

(2) on price and quality information on health care providers (including physicians, hospitals, and other health care institutions).

(b) PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act the Secretary of Health and Human Services shall work with

States to establish no later than January 1, 2013, consistent with this title, a Web site that will serve as a pilot program for a national portal for information structured in a manner so individuals may directly link to the State plan portal for the State in which they reside.

(2) CONTRACTS WITH STATE.—The Secretary shall enter into contracts with States, in a number and distribution determined by the Secretary, to develop State plan portals that follow the applicable standards and regulations under this section.

(3) COMMON STANDARDS FOR PLAN PORTALS.—

(A) IN GENERAL.—In connection with such Web site, the Secretary shall establish standards for interoperability and consistency for State plan portals so that individuals can access and view information in a similar manner on plan portals of different States. Such standards shall include standard definitions for health insurance plan benefits so that individuals can accurately compare health insurance plans within such portals and standards for the inclusion of information described in subsection (c).

(B) CONSULTATION.—The Secretary shall consult with a group consisting of a balanced representation of the critical stakeholders (including States, health insurance issuers, the National Association of Insurance Commissioners, qualified health care provider-based entities (including physicians, hospitals, and other health care institutions), and a standards development organization) to develop such standards.

(C) ISSUANCE.—

(i) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall issue, by regulation, after notice and opportunity for public comment, standards that are consistent with the recommendations made by the group under subparagraph (B).

(ii) DISSEMINATION.—The Secretary shall broadly disseminate the standards so issued.

(D) REVIEW.—One year after the date of establishment of the pilot program under this subsection, the Secretary, in consultation with stakeholder group described in subparagraph

(B), shall review the standards established and make such changes in such standards as may be appropriate.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such amounts as may be necessary for—

(A) the development and operation of the national Web site under this subsection; and

(B) contracts with States under paragraph (2) to assist in the development and initial operation of plan portals in accordance with standards established under paragraph (3) and other applicable provisions of this section.

(c) INFORMATION IN PLAN PORTALS.—The standards for plan portals under subsection (b)(3) shall include the following:

(1) HEALTH INSURANCE INFORMATION.—Each plan portal shall meet the following requirements with respect to information on health insurance plans:

(A) The plan portal shall present complete information on the costs and benefits of health insurance plans (including information on monthly premium, copayments, deductibles, and covered benefits) in a uniform manner that—

(i) uses the standard definitions developed under subsection (b)(3); and

(ii) is designed to allow consumers to easily compare such plans.

(B) The plan portal shall be available on the internet and accessible to all individuals in the United States.

(C) The plan portal shall allow consumers to search and sort data on the health insurance plans in the plan portal on criteria such as coverage of specific benefits (such as coverage of disease management services or pediatric care services), as well as data available respecting quality of plans.

(D) The plan portal shall meet all relevant State laws and regulations, including laws and regulations related to the marketing of insurance products.

(E) Notwithstanding subsection (d)(1), the plan portal shall provide information to individuals who are eligible for the Medicaid program under title XIX of the Social Security Act or State Children's Health Insurance Program under title XXI of such Act by including information on options, eligibility, and how to enroll

through providing a link to a Web site maintained with respect to such State programs.

(F) The plan portal shall provide support to individuals who are eligible for tax credits and deductions under the amendments made by this Act to enhance such individual's ability to access such credits and deductions.

(G) The plan portal shall allow consumers to access quality data on providers as made available through a Web site described in section 802 once that data is available.

(2) PROVIDER INFORMATION.—Each plan portal shall meet the following requirements with respect to information on health care providers:

(A) Identifying and licensure information.

(B) Self-pay prices charged, including variation in such prices.

For purposes of subparagraph (B), the term ''self-pay price'' means the price charged by a provider to individuals for items or services where the price is not established or negotiated through a health care program or third party.

(3) TAX CREDIT AND DEDUCTION INFORMATION.—Each plan portal shall also include informa-

tion on tax credits and deductions that may be available for purpose of qualified health plans.

(4) INCLUSION OF QUALITY INFORMATION.—The Secretary, after collaboration with States and health care providers (including practicing physicians, hospitals, and other health care institutions), shall submit to Congress recommendations on how to include on plan portals information on performance-based quality measures obtained under section 802.

(d) PROHIBITIONS.—

(1) DIRECT ENROLLMENT.—A plan portal may not directly enroll individuals in health insurance plans or under a State Medicaid plan or a State children's health insurance plan.

(2) CONFLICTS OF INTEREST.—

(A) COMPANIES.—A health insurance issuer offering a health insurance plan through a plan portal may not—

(i) be the private entity developing and maintaining a plan portal under this section; or

(ii) have an ownership interest in such private entity or in the plan portal.

(B) INDIVIDUALS.—An individual employed by a health insurance issuer offering a health insurance plan through a plan portal may not serve as a director or officer for—

(i) the private entity developing and maintaining a plan portal under this section; or

(ii) the plan portal.

(e) CONSTRUCTION.—Nothing in this section shall be construed to prohibit health insurance brokers and agents from—

(1) utilizing the plan portal for any purpose; or

(2) marketing or offering health insurance products.

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

(g) HEALTH INSURANCE PLANS.—For purposes of this section, the term ''health insurance plan'' does not include coverage of excepted benefits, as defined in section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

TITLE X—PATIENT FREEDOM OF CHOICE

SEC. 1001. GUARANTEEING FREEDOM OF CHOICE AND CONTRACTING FOR PATIENTS UNDER MEDICARE.

(a) IN GENERAL.—Section 1802 of the Social Security Act (42 U.S.C. 1395a) is amended to read as follows:

''FREEDOM OF CHOICE AND CONTRACTING BY PATIENT GUARANTEED

''SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide that individual such services.

''(b) FREEDOM TO CONTRACT BY MEDICARE BENEFICIARIES.—

''(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a Medicare beneficiary from entering into a contract with an eligible professional (whether or not the professional is a participating or non-participating physician or practitioner) for any item or service covered under this title.

''(2) SUBMISSION OF CLAIMS.—Any Medicare beneficiary that enters into a contract under this

section with an eligible professional shall be permitted to submit a claim for payment under this title for services furnished by such professional, and such payment shall be made in the amount that would otherwise apply to such professional under this title except that where such professional is considered to be non-participating, payment shall be paid as if the professional were participating. Payment made under this title for any item or service provided under the contract shall not render the professional a participating or non-participating physician or practitioner, and as such, requirements of this title that may otherwise apply to a participating or non-participating physician or practitioner would not apply with respect to any items or services furnished under the contract.

''(3) BENEFICIARY PROTECTIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

''(i) the contract is in writing, is signed by the Medicare beneficiary and the eligible professional, and establishes all terms of the contract (including specific payment for items and services covered by the contract) before any item or service is

provided pursuant to the contract, and the beneficiary shall be held harmless for any subsequent payment charged for an item or service in excess of the amount established under the contract during the period the contract is in effect;

''(ii) the contract contains the items described in subparagraph (B); and

''(iii) the contract is not entered into at a time when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation.

''(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the Medicare beneficiary that by signing such contract the beneficiary—

''(i) agrees to be responsible for payment to such eligible professional for such items or services under the terms of and amounts established under the contract;

''(ii) agrees to be responsible for submitting claims under this title to the Secretary, and to any other supplemental insurance plan that may provide supple-

mental insurance, for such items or services furnished under the contract if such items or services are covered by this title, unless otherwise provided in the contract under subparagraph (C)(i); and

"(iii) acknowledges that no limits or other payment incentives that may otherwise apply under this title (such as the limits under subsection (g) of section 1848 or incentives under subsection (a)(5), (m), (q), and (p) of such section) shall apply to amounts that may be charged, or paid to a beneficiary for, such items or services.

Such contract shall also clearly indicate whether the eligible professional is excluded from participation under the Medicare program under section 1128.

"(C) BENEFICIARY ELECTIONS UNDER THE CONTRACT.—Any Medicare beneficiary that enters into a contract under this section may elect to negotiate, as a term of the contract, a provision under which—

"(i) the eligible professional shall file claims on behalf of the beneficiary with the Secretary and any supplemental insurance

plan for items or services furnished under the contract if such items or services are covered under this title or under the plan; and

''(ii) the beneficiary assigns payment to the eligible professional for any claims filed by, or on behalf of, the beneficiary with the Secretary and any supplemental insurance plan for items or services furnished under the contract.

''(D) EXCLUSION OF DUAL ELIGIBLE INDIVIDUALS.—Paragraph (1) shall not apply to any contract if a beneficiary who is eligible for medical assistance under title XIX is a party to the contract.

''(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a Medicare beneficiary under a contract described in paragraph (1).

''(5) CONSTRUCTION.—Nothing in this section shall be construed—

''(A) to prohibit any eligible professional from maintaining an election and acting as a participating or non-participating physician or

practitioner with respect to any patient not covered under a contract established under this section; and

"(B) as changing the items and services for which an eligible professional may bill under this title.

"(6) DEFINITIONS.—In this subsection:

"(A) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given such term in section 1848(k)(3)(B).

"(C) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) serious jeopardy to the health of the individual or, in the case of a pregnant

woman, the health of the woman or her unborn child;

"(ii) serious impairment to bodily functions; or

"(iii) serious dysfunction of any bodily organ or part.

"(D) URGENT HEALTH CARE SITUATION.—The term 'urgent health care situation' means services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.".

SEC. 1002. PREEMPTION OF STATE LAWS LIMITING CHARGES FOR ELIGIBLE PROFESSIONAL SERVICES.

(a) IN GENERAL.—No State may impose a limit on the amount of charges for services, furnished by an eligible professional (as defined in subsection (k)(3)(B) of section 1848 of the Social Security Act, 42 U.S.C. 1395w–4), for which payment is made under such section, and any such limit is hereby preempted.

(b) STATE.—In this section, the term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 1003. HEALTH CARE PROVIDER LICENSURE CANNOT BE CONDITIONED ON PARTICIPATION IN A HEALTH PLAN.

(a) IN GENERAL.—The Secretary of Health and Human Services and any State (as a condition of receiving Federal financial participation under title XIX of the Social Security Act) may not require any health care provider to participate in any health plan as a condition of licensure of the provider in any State.

(b) DEFINITIONS.—In this section:

(1) HEALTH PLAN.—The term ''health plan'' has the meaning given such term in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5)).

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity that is required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services and is so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(3) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

SEC. 1004. BAD DEBT DEDUCTION FOR DOCTORS TO PARTIALLY OFFSET THE COST OF PROVIDING UNCOMPENSATED CARE REQUIRED TO BE PROVIDED UNDER AMENDMENTS MADE BY THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT.

(a) IN GENERAL.—Section 166 of the Internal Revenue Code of 1986 (relating to bad debts) is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

''(f) BAD DEBT TREATMENT FOR DOCTORS TO PARTIALLY OFFSET COST OF PROVIDING UNCOMPENSATED CARE REQUIRED TO BE PROVIDED.—

''(1) AMOUNT OF DEDUCTION.—

''(A) IN GENERAL.—For purposes of subsection (a), the basis for determining the amount of any deduction for an eligible EMTALA debt shall be treated as being equal to the Medicare payment amount.

''(B) MEDICARE PAYMENT AMOUNT.—For purposes of subparagraph (A), the Medicare payment amount with respect to an eligible EMTALA debt is the fee schedule amount established under section 1848 of the Social Security Act for the physicians' service (to which such debt relates) as if the service were pro-

vided to an individual enrolled under part B of title XVIIII of such Act.

''(2) ELIGIBLE EMTALA DEBT.—For purposes of this section, the term 'eligible EMTALA debt' means any debt if—

''(A) such debt arose as a result of physicians' services—

''(i) which were performed in an EMTALA hospital by a board-certified physician (whether as part of medical screening or necessary stabilizing treatment and whether as an emergency department physician, as an on-call physician, or otherwise), and

''(ii) which were required to be provided under section 1867 of the Social Security Act (42 U.S.C. 1395dd), and

''(B) such debt is owed—

''(i) to such physician, or

''(ii) to an entity if—

''(I) such entity is a corporation and the sole shareholder of such corporation is such physician, or

''(II) such entity is a partnership and any deduction under this sub-

section with respect to such debt is allocated to such physician or to an entity described in subclause (I).

''(3) BOARD-CERTIFIED PHYSICIAN.—For purposes of this subsection, the term 'board-certified physician' means any physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) who is certified by the American Board of Emergency Medicine or other appropriate medical specialty board for the specialty in which the physician practices, or who meets comparable requirements, as identified by the Secretary of the Treasury in consultation with Secretary of Health and Human Services.

''(4) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) EMTALA HOSPITAL.—The term 'EMTALA hospital' means any hospital having a hospital emergency department which is required to comply with section 1867 of the Social Security Act (42 U.S.C. 1395dd) (relating to examination and treatment for emergency medical conditions and women in labor).

''(B) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given

such term in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to debts arising from services performed in taxable years beginning after the date of the enactment of this Act.

SEC. 1005. RIGHT OF CONTRACT WITH HEALTH CARE PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall not preclude an enrollee, participant, or beneficiary in a health benefits plan from entering into any contract or arrangement for health care with any health care provider.

(b) HEALTH BENEFITS PLAN DEFINED.—

(1) IN GENERAL.—In this section, subject to paragraph (2), the term ''health benefits plan'' means any of the following:

(A) Group health plan (as defined in section 2791 of the Public Health Service Act).

(B) Health insurance coverage (as defined in section 2791 of such Act).

(C) A health benefits plan under chapter 89 of title 5, United States Code.

(2) EXCLUSION OF MEDICAID AND TRICARE.—Such term does not include a health plan participating in—

(A) the Medicaid program under title XIX of the Social Security Act; or

(B) the TRICARE program under chapter 55 of title 10, United States Code.

(c) HEALTH CARE PROVIDER DEFINED.—In this section, the term ''health care provider'' means—

(1) a physician, as defined in paragraphs (1), (2), (3), and (4) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)); and

(2) a health care practitioner described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)).

TITLE XI—INCENTIVES TO REDUCE PHYSICIAN SHORTAGES

Subtitle A—Federally Supported Student Loan Funds for Medical Students

SEC. 1101. FEDERALLY SUPPORTED STUDENT LOAN FUNDS FOR MEDICAL STUDENTS.

(a) PRIMARY HEALTH CARE MEDICAL STUDENTS.—Subpart II of part A of the Public Health Service Act (42 U.S.C. 292q et seq.) is amended—

(1) by redesignating section 735 as section 729; and

(2) in subsection (f) of section 729 (as so redesignated), by striking ''is authorized to be appropriated $10,000,000 for each of the fiscal years 1994 through 1996'' and inserting ''are authorized to be appropriated such sums as may be necessary for fiscal year 2012 and each fiscal year thereafter''.

(b) OTHER MEDICAL STUDENTS.—Part A of title VII of the Public Health Service Act (42 U.S.C. 292 et seq.) is amended by adding at the end the following:

''Subpart III—Federally Supported Student Loan Funds for Certain Medical Students

''SEC. 730. SCHOOL LOAN FUNDS FOR CERTAIN MEDICAL STUDENTS.

''(a) FUND AGREEMENTS.—For the purpose described in subsection (b), the Secretary is authorized to enter into an agreement for the establishment and operation of a student loan fund with any public or nonprofit school of medicine or osteopathic medicine.

''(b) PURPOSE.—The purpose of this subpart is to provide for loans to medical students who would be eligible for a loan under subpart II, except for the student's decision to enter a residency training program in a field other than primary health care.

''(c) COMMENCEMENT OF REPAYMENT PERIOD.—The repayment period for a loan under this section shall not begin before the end of any period during which the student is participating in an internship, residency, or fellowship training program directly related to the field of medicine which the student agrees to enter pursuant to subsection (d).

''(d) REQUIREMENTS FOR STUDENTS.—Each agreement under this section for the establishment of a student loan fund shall provide that the school of medicine or osteopathic medicine will make a loan to a student from such fund only if the student agrees—

''(1) to enter and complete a residency training program (in a field of medicine other than primary health care) not later than a period determined by the Secretary to be reasonable after the date on which the student graduates from such school; and

''(2) to practice medicine through the date on which the loan is repaid in full.

''(e) REQUIREMENTS FOR SCHOOLS.—The provisions of section 723(b) (regarding graduates in primary health care) shall not apply to a student loan fund established under this section.

''(f) APPLICABILITY OF OTHER PROVISIONS.—Except as inconsistent with this section, the provisions of

subpart II shall apply to the program of student loan funds established under this section to the same extent and in the same manner as such provisions apply to the program of student loan funds established under subpart II.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2012 and each fiscal year thereafter.''.

Subtitle B—Loan Forgiveness for Primary Care Providers

SEC. 1111. LOAN FORGIVENESS FOR PRIMARY CARE PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall carry out a program of entering into contracts with eligible individuals under which—

(1) the individual agrees to serve for a period of not less than 5 years as a primary care provider; and

(2) in consideration of such service, the Secretary agrees to pay not more than $50,000 on the principal and interest on the individual's graduate educational loans.

(b) ELIGIBILITY.—To be eligible to enter into a contract under subsection (a), an individual must—

(1) have a graduate degree in medicine, osteopathic medicine, or another health profession from an accredited (as determined by the Secretary of Health and Human Services) institution of higher education; and

(2) have practiced as a primary care provider for a period (excluding any residency or fellowship training period) of not less than—

(A) 5 years; or

(B) 3 years in a medically underserved community (as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p)).

(c) INSTALLMENTS.—Payments under this section may be made in installments of not more than $10,000 for each year of service described in subsection (a)(1).

(d) APPLICABILITY OF CERTAIN PROVISIONS.—The provisions of subpart III of part D of title III of the Public Health Service Act shall, except as inconsistent with this section, apply to the program established under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established in such subpart.

TITLE XII—QUALITY HEALTH CARE COALITION

SEC. 1201. QUALITY HEALTH CARE COALITION.

(a) APPLICATION OF THE FEDERAL ANTITRUST LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING WITH HEALTH PLANS.—

(1) IN GENERAL.—Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be exempt from the Federal antitrust laws.

(2) LIMITATION.—

(A) NO NEW RIGHT FOR COLLECTIVE CESSATION OF SERVICE.—The exemption provided in paragraph (1) shall not confer any new right to participate in any collective cessation of service to patients not already permitted by existing law.

(B) NO CHANGE IN NATIONAL LABOR RELATIONS ACT.—This section applies only to health care professionals excluded from the National Labor Relations Act. Nothing in this section shall be construed as changing or amend-

ing any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.

(3) NO APPLICATION TO FEDERAL PROGRAMS.—Nothing in this section shall apply to negotiations between health care professionals and health plans pertaining to benefits provided under any of the following:

(A) The Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) The Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(C) The SCHIP program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(D) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(E) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

(F) Chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

(G) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) DEFINITIONS.—In this section, the following definitions shall apply:

(1) ANTITRUST LAWS.—The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) GROUP HEALTH PLAN.—The term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(3) GROUP HEALTH PLAN, HEALTH INSURANCE ISSUER.—The terms ''group health plan'' and ''health insurance issuer'' include a third-party ad-

ministrator or other person acting for or on behalf of such plan or issuer.

(4) HEALTH CARE SERVICES.—The term ''health care services'' means any services for which payment may be made under a health plan, including services related to the delivery or administration of such services.

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual or entity that provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

(6) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(7) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a State and that is subject to State law regulating insurance. Such term does not include a group health plan.

(8) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a)));

(B) an organization recognized under State law as a health maintenance organization; or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(9) HEALTH PLAN.—The term ''health plan'' means a group health plan or a health insurance issuer that is offering health insurance coverage.

(10) MEDICAL CARE.—The term ''medical care'' means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; and

(B) transportation primarily for and essential to receiving items and services referred to in subparagraph (A).

(11) PERSON.—The term ''person'' includes a State or unit of local government.

(12) STATE.—The term ''State'' includes the several States, the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(c) EFFECTIVE DATE.—This section shall take effect on on the date of the enactment of this Act and shall not apply with respect to conduct occurring before such date.

TITLE XIII—OFFSETS

Subtitle A—Discretionary Spending Limits

SEC. 1301. DISCRETIONARY SPENDING LIMITS.

Section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(c)), as

amended by section 101 of the Budget Control Act of 2011, is amended to read as follows:

''(c) DISCRETIONARY SPENDING LIMIT.—As used in this part, the term 'discretionary spending limit' means—

''(1) with respect to fiscal year 2012—

''(A) for the security category, $684,000,000,000 in new budget authority; and

''(B) for the nonsecurity category, $359,000,000,000 in new budget authority;

''(2) with respect to fiscal year 2013—

''(A) for the security category, $698,000,000,000 in new budget authority; and

''(B) for the nonsecurity category, $329,000,000,000 in new budget authority;

''(3) with respect to fiscal year 2014, for the discretionary category, $1,038,537,000,000 in new budget authority;

''(4) with respect to fiscal year 2015, for the discretionary category, $1,046,680,000,000 in new budget authority;

''(5) with respect to fiscal year 2016, for the discretionary category, $1,055,779,000,000 in new budget authority;

''(6) with respect to fiscal year 2017, for the discretionary category, $1,067,794,000,000 in new budget authority;

''(7) with respect to fiscal year 2018, for the discretionary category, $1,085,259,000,000 in new budget authority;

''(8) with respect to fiscal year 2019, for the discretionary category, $1,103,802,000,000 in new budget authority;

''(9) with respect to fiscal year 2020, for the discretionary category, $1,122,611,000,000 in new budget authority; and

''(10) with respect to fiscal year 2021, for the discretionary category, $1,141,640,000,000 in new budget authority;

as adjusted in strict conformance with subsection (b).''.

Subtitle B—Savings From Health Care Efficiencies

SEC. 1311. MEDICARE DSH REPORT AND PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.

(a) DSH REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH

taking into account the impact of the health care reforms carried out under this Act in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(A) The appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), consistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent such costs remain.

(2) COORDINATION WITH MEDICAID DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicaid DSH under section 1322(a).

(b) PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.—

(1) IN GENERAL.—If there is a significant decrease in the national rate of uninsurance as a result

of this Act (as determined under paragraph (2)(A)), then the Secretary of Health and Human Services shall, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH:

(A) In lieu of the amount of Medicare DSH payment that would otherwise be made under section 1886(d)(5)(F) of the Social Security Act, the amount of Medicare DSH payment shall be an amount based on the recommendations of the report under subsection (a)(1)(A) and shall take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size.

(B) Subject to paragraph (3), make an additional payment to a hospital by an amount that is estimated based on the amount of uncompensated care provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

(2) SIGNIFICANT DECREASE IN NATIONAL RATE OF UNINSURANCE AS A RESULT OF THIS ACT.—For purposes of this subsection—

(A) IN GENERAL.—There is a ''significant decrease in the national rate of uninsurance as a result of this Act'' if there is a decrease in the national rate of uninsurance (as defined in subparagraph (B)) from 2012 to 2014 that exceeds 8 percentage points.

(B) NATIONAL RATE OF UNINSURANCE DEFINED.—The term ''national rate of uninsurance'' means, for a year, such rate for the under-65 population for the year as determined and published by the Bureau of the Census in its Current Population Survey in or about September of the succeeding year.

(3) UNCOMPENSATED CARE INCREASE.—

(A) COMPUTATION OF DSH SAVINGS.—For each fiscal year (beginning with fiscal year 2015), the Secretary shall estimate the aggregate reduction in Medicare DSH that will result from the adjustment under paragraph (1)(A).

(B) STRUCTURE OF PAYMENT INCREASE.—The Secretary shall compute the increase in Medicare DSH under paragraph (1)(B) for a fiscal year in accordance with a formula established by the Secretary that provides that—

(i) the aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH estimated by the Secretary for such fiscal year; and

(ii) hospitals with higher levels of uncompensated care receive a greater increase.

(c) MEDICARE DSH.—In this section, the term ''Medicare DSH'' means adjustments in payments under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services furnished by disproportionate share hospitals.

SEC. 1312. REDUCTION IN MEDICAID DSH.

(a) REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this title referred to as the ''Secretary'') shall submit to Congress a report concerning the extent to which, based upon the impact of the health care reforms carried out under this Act in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH. In preparing the report, the Secretary shall consult with community-based

health care networks serving low-income beneficiaries.

(2) MATTERS TO BE INCLUDED.—The report shall include the following:

(A) RECOMMENDATIONS.—Recommendations regarding—

(i) the appropriate targeting of Medicaid DSH within States; and

(ii) the distribution of Medicaid DSH among the States.

(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in paragraph (2) of subsection (b) for purposes of implementing the requirements of such subsection.

(3) COORDINATION WITH MEDICARE DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicare DSH under section 1321.

(4) MEDICAID DSH.—In this section, the term ''Medicaid DSH'' means adjustments in payments under section 1923 of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals.

(b) MEDICAID DSH REDUCTIONS.—

(1) IN GENERAL.—If there is a significant decrease in the national rate of uninsurance as a result of this Act (as determined under section 1321(a)(2)(A)), then the Secretary of Health and Human Services shall reduce Medicaid DSH so as to reduce total Federal payments to all States for such purpose by $1,500,000,000 in fiscal year 2017, $2,500,000,000 in fiscal year 2018, and $6,000,000,000 in fiscal year 2019.

(2) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out paragraph (1) through use of a DSH Health Reform methodology issued by the Secretary that imposes the largest percentage reductions on the States that—

(A) have the lowest percentages of uninsured individuals (determined on the basis of audited hospital cost reports) during the most recent year for which such data are available; or

(B) do not target their DSH payments on—

(i) hospitals with high volumes of Medicaid inpatients (as defined in section 1923(b)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(b)(1)(A))); and

(ii) hospitals that have high levels of uncompensated care (excluding bad debt).

(3) DSH ALLOTMENT PUBLICATIONS.—

(A) IN GENERAL.—Not later than the publication deadline specified in subparagraph (B), the Secretary shall publish in the Federal Register a notice specifying the DSH allotment to each State under 1923(f) of the Social Security Act for the respective fiscal year specified in such subparagraph, consistent with the application of the DSH Health Reform methodology described in paragraph (2).

(B) PUBLICATION DEADLINE.—The publication deadline specified in this subparagraph is—

(i) January 1, 2016, with respect to DSH allotments described in subparagraph (A) for fiscal year 2017;

(ii) January 1, 2017, with respect to DSH allotments described in subparagraph (A) for fiscal year 2018; and

(iii) January 1, 2018, with respect to DSH allotments described in subparagraph (A) for fiscal year 2019.

(c) CONFORMING AMENDMENTS.—

(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

''(7) SPECIAL RULE FOR FISCAL YEARS 2017, 2018, AND 2019.—Notwithstanding paragraph (2), if the Secretary makes a reduction under section 1322(b)(1) of the Empowering Patients First Act, the total DSH allotments for all States for—

''(A) fiscal year 2017, shall be the total DSH allotments that would otherwise be determined under this subsection for such fiscal year decreased by $1,500,000,000;

''(B) fiscal year 2018, shall be the total DSH allotments that would otherwise be determined under this subsection for such fiscal year decreased by $2,500,000,000; and

''(C) fiscal year 2019, shall be the total DSH allotments that would otherwise be determined under this subsection for such fiscal year decreased by $6,000,000,000.''.

(2) Section 1923(b)(4) of such Act (42 U.S.C. 1396r–4(b)(4)) is amended by adding before the pe-

riod the following: ''or to affect the authority of the Secretary to issue and implement the DSH Health Reform methodology under section 1322(b)(2) of the Empowering Patients First Act''.

(d) DISPROPORTIONATE SHARE HOSPITALS (DSH) AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DISCRIMINATION.—

(1) IN GENERAL.—Section 1923(d) of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following new paragraph:

''(4) No hospital may be defined or deemed as a disproportionate share hospital, or as an essential access hospital (for purposes of subsection (f)(6)(A)(iv)), under a State plan under this title or subsection (b) of this section (including any waiver under section 1115) unless the hospital—

''(A) provides services to beneficiaries under this title without discrimination on the ground of race, color, national origin, creed, source of payment, status as a beneficiary under this title, or any other ground unrelated to such beneficiary's need for the services or the availability of the needed services in the hospital; and

''(B) makes arrangements for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title.''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall be apply to expenditures made on or after July 1, 2012.

Subtitle C—Fraud, Waste, and Abuse

SEC. 1321. PROVIDE ADEQUATE FUNDING TO HHS OIG AND HCFAC.

(a) HCFAC FUNDING.—Section 1817(k)(3)(A) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (IV), by striking at the end ''and'';

(B) in subclause (V)—

(i) by striking ''for each fiscal year after fiscal year 2010'' and inserting ''for fiscal year 2011''; and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(VI) for each fiscal year after fiscal year 2011, $300,000,000.''; and

(2) in clause (ii)—

(A) in subclause (IX), by striking at the end ''and'';

(B) in subclause (X)—

(i) by striking ''for each fiscal year after fiscal year 2010'' and inserting ''for fiscal year 2011''; and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(XI) for each fiscal year after fiscal year 2011, not less than the amount required under this clause for fiscal year 2011, plus the amount by which the amount made available under clause (i)(VI) for fiscal year 2012 exceeds the amount made available under clause (i)(V) for fiscal year 2011.''.

(b) OIG FUNDING.—There are authorized to be appropriated for each of fiscal years 2012 through 2021 $100,000,000 for the Office of the Inspector General of

the Department of Health and Human Services for fraud prevention activities under the Medicare and Medicaid programs.

SEC. 1322. IMPROVED ENFORCEMENT OF THE MEDICARE SECONDARY PAYOR PROVISIONS.

(a) IN GENERAL.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, shall provide through the Coordination of Benefits Contractor for the identification of instances where the Medicare program should be, but is not, acting as a secondary payer to an individual's private health benefits coverage under section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)).

(b) UPDATING PROCEDURES.—The Secretary shall update procedures for identifying and resolving credit balance situations which occur under the Medicare program when payment under such title and from other health benefit plans exceed the providers' charges or the allowed amount.

(c) REPORT ON IMPROVED ENFORCEMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on progress made in improved enforcement of the Medicare secondary payor provisions, including recoupment of credit balances.

SEC. 1323. STRENGTHEN MEDICARE PROVIDER ENROLLMENT STANDARDS AND SAFEGUARDS.

(a) STRENGTHENING MEDICARE PROVIDER NUMBERS.—

(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 (referred to in this section as the ''Secretary'') shall screen the provider or supplier for a criminal background or other financial or operational irregularities through fingerprinting, licensure checks, site-visits, and 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).

(3) PROVISIONAL APPROVAL.—During an initial, provisional period (specified by the Secretary) in which such a provider or supplier has been issued such a number, the Secretary shall provide enhanced

oversight of the activities of such provider or supplier under the Medicare program, such as through prepayment review and payment limitations.

(4) PENALTIES FOR FALSE STATEMENTS.—In the case of a provider or supplier that knowingly makes a false statement in an application for such a number, the Secretary may exclude the provider or supplier from participation under the Medicare program, or may impose a civil money penalty (in the amount described in section 1128A(a)(4) of the Social Security Act), in the same manner as the Secretary may impose such an exclusion or penalty under sections 1128 and 1128A, respectively, of such Act in the case of knowing presentation of a false claim described in section 1128A(a)(1)(A) of such Act.

(5) DISCLOSURE REQUIREMENTS.—With respect to approval of such an application, the Secretary—

(A) shall require applicants to disclose previous affiliation with enrolled entities that have uncollected debt related to the Medicare or Medicaid programs;

(B) may deny approval if the Secretary determines that these affiliations pose undue risk

to the Medicare or Medicaid program, subject to an appeals process for the applicant as determined by the Secretary; and

(C) may implement enhanced safeguards (such as surety bonds).

(b) MORATORIA.—The Secretary may impose moratoria on approval of provider and supplier numbers under the Medicare program for new providers of services and suppliers as determined necessary to prevent or combat fraud a period of delay for any one applicant cannot exceed 30 days unless cause is shown by the Secretary.

(c) FUNDING.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 1324. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

(a) GREATER COORDINATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') 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 pro-

gram 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

(B) such information can be shared across Federal health care programs and agencies, including between the Departments of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Department of Defense, the Department of Justice, and the Office of Personnel Management.

(c) MEDICARE/MEDICAID ''ONE PI'' DATABASE.—The Secretary shall implement a database that includes claims and payment data for all components of the Medicare program and the Medicaid program.

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

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

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

(e) CONSOLIDATION OF DATA BASES.—The Secretary shall consolidate and expand into a centralized data base for individuals and entities that have been excluded from Federal health care programs the Healthcare Integrity and Protection Data Bank, the National Practitioner Data Bank, the List of Excluded Individuals/Entities, and a national patient abuse/neglect registry.

(f) COMPREHENSIVE PROVIDER DATABASE.—

(1) ESTABLISHMENT.—The Secretary shall establish a comprehensive database that includes information on providers of services, suppliers, and related entities participating in the Medicare program, the Medicaid program, or both. Such database shall include, information on ownership and business rela-

tionships, history of adverse actions, results of site visits or other monitoring by any program.

(2) USE.—Prior to issuing a provider or supplier number for an entity under the Medicare program, the Secretary shall obtain information on the entity from such database to assure the entity qualifies for the issuance of such a number.

(g) COMPREHENSIVE SANCTIONS DATABASE.—The Secretary shall establish a comprehensive sanctions database on sanctions imposed on providers of services, suppliers, and related entities. Such database shall be overseen by the Inspector General of the Department of Health and Human Services and shall be linked to related databases maintained by State licensure boards and by Federal or State law enforcement agencies.

(h) ACCESS TO CLAIMS AND PAYMENT DATABASES.—The Secretary shall ensure that the Inspector General of the Department of Health and Human Services and Federal law enforcement agencies have direct access to all claims and payment databases of the Secretary under the Medicare or Medicaid programs.

(i) CIVIL MONEY PENALTIES FOR SUBMISSION OF ERRONEOUS INFORMATION.—In the case of a provider of services, supplier, or other entity that knowingly submits erroneous information that serves as a basis for payment

of any entity under the Medicare or Medicaid program, the Secretary may impose a civil money penalty of not to exceed $50,000 for each such erroneous submission. A civil money penalty under this subsection shall be imposed and collected in the same manner as a civil money penalty under subsection (a) of section 1128A of the Social Security Act is imposed and collected under that section.

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