I

113TH CONGRESS
1ST SESSION

H. R. 3165

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 20, 2013

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

A BILL

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

Be it enacted by the Senate and House of Representa-
tives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE; PURPOSE; TABLE OF CONTENTS.

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

(b) PURPOSE.—The purpose of this Act is to take meaningful steps to lower health care costs and increase access to health insurance coverage (especially for individuals with preexisting conditions) without—

(1) raising taxes;

(2) cutting Medicare benefits for seniors;

(3) adding to the national deficit;

(4) intervening in the doctor-patient relationship; or

(5) instituting a government takeover of health care.

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

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

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

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

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

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Subtitle A—Enhanced Marketplace Pools
Sec. 201. Rules governing enhanced marketplace pools.
Sec. 203. Effective date and transitional and other rules.

Subtitle B—Market Relief

Sec. 204. Market relief.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS

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

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

Sec. 221. Interstate purchasing of health insurance.

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

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

TITLE V—TAX–RELATED HEALTH INCENTIVES

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

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

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

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
Sec. 401. Rule of construction.
Sec. 402. Repeal of Federal Coordinating Council for Comparative Effectiveness Research.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

Sec. 501. Incentives for prevention and wellness programs.

DIVISION F—PROTECTING TAXPAYERS

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


(a) PATIENT PROTECTION AND AFFORDABLE CARE ACT.—The Patient Protection and Affordable Care Act (Public Law 111–148) 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 AND EDUCATION RECONCILIATION ACT OF 2010.—The Health Care and Education Reconciliation Act of 2010 (Public Law 111–152) 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.
DIVISION A—ENSURING COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

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

(a) STATE REQUIREMENT.—

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

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

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

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

(A) STATES NOT OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that
is not operating a current section 2745 qualified high risk pool as of the date of the enactment of this Act, the State's operation of a qualifying State high risk pool described in subsection (b)(1) shall be treated, for purposes of section 2745 of the Public Health Service Act, as the operation of a qualified high risk pool described in such section.

(B) State operating a qualified high risk pool.—In the case of a State that is operating a current section 2745 qualified high risk pool as of the date of the enactment of this Act, as of the date that is 90 days after the date of the enactment of this Act, such a pool shall not be treated as a qualified high risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in subsection (b)(1).

(3) Application of funds.—If the pool operated under paragraph (1)(A) is in strong fiscal health, as determined in accordance with standards established by the National Association of Insurance Commissioners and as approved by the State Insurance Commissioner involved, the requirement of paragraph (1)(B) shall be deemed to be met.
(b) Qualifying State High Risk Pool.—

(1) In general.—A qualifying State high risk pool described in this subsection means a current section 2745 qualified high risk pool that meets the following requirements:

(A) The pool must be funded with a stable funding source.

(B) The pool must eliminate any waiting lists so that all eligible residents who are seeking coverage through the pool should be allowed to receive coverage through the pool.

(C) The pool must allow for coverage of individuals who, but for the 24-month disability waiting period under section 226(b) of the Social Security Act, would be eligible for Medicare during the period of such waiting period.

(D) The pool must limit the pool premiums to no more than 150 percent of the average premium for applicable standard risk rates in that State.

(E) The pool must conduct education and outreach initiatives so that residents and brokers understand that the pool is available to eligible residents.
(F) The pool must provide coverage for preventive services and disease management for chronic diseases.

(G) Subject to subparagraph (C), an individual may only be eligible for coverage through the pool if the individual has a pre-existing condition, as determined in a manner consistent with guidance used by the Secretary of Health and Human Services and—

(i) was denied health insurance coverage in the individual market because of a pre-existing condition or health status; or

(ii) was offered such coverage—

(I) under terms that limit the coverage for such a pre-existing condition; or

(II) at a premium rate that is above the premium rate for coverage through the pool pursuant to this section.

(H) No pre-existing condition exclusion period may be imposed on coverage through the pool.

(I) The pool shall not require an individual to be uninsured for any period as a condition
of eligibility to receive coverage through the pool.

(2) VERIFICATION OF CITIZENSHIP OR ALIEN QUALIFICATION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, only citizens and nationals of the United States shall be eligible to participate in a qualifying State high risk pool that receives funds under section 2745 of the Public Health Service Act or this section.

(B) CONDITION OF PARTICIPATION.—As a condition of a State receiving such funds, the Secretary shall require the State to certify, to the satisfaction of the Secretary, that such State requires all applicants for coverage in the qualifying State high risk pool to provide satisfactory documentation of citizenship or nationality in a manner consistent with section 1903(x) of the Social Security Act.

(C) RECORDS.—The Secretary shall keep sufficient records such that a determination of citizenship or nationality only has to be made once for any individual under this paragraph.

(3) RELATION TO SECTION 2745.—As of January 1, 2012, a pool shall not qualify as qualified
high risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in paragraph (1).

(c) Waivers.—In order to accommodate new and innovative programs, the Secretary may waive such requirements of this section for qualifying State high risk pools as the Secretary deems appropriate.

(d) Funding.—In addition to any other amounts appropriated, there is appropriated to carry out section 2745 of the Public Health Service Act (including through a pool described in subsection (a)(1))—

(1) $15,000,000,000 for the period of fiscal years 2011 through 2021; and

(2) an additional $10,000,000,000 for the period of fiscal years 2017 through 2021.

(e) Definitions.—In this section:

(1) Health insurance coverage; health insurance issuer.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms in section 2791 of the Public Health Service Act.

(2) Current section 2745 qualified high risk pool.—The term “current section 2745 qualified high risk pool” has the meaning given the term “qualified high risk pool” under section 2745(g) of
the Public Health Service Act as in effect as of the
date of the enactment of this Act.

(3) SECRETARY.—The term “Secretary” means
Secretary of Health and Human Services.

(4) STANDARD RISK RATE.—The term “standard
risk rate” means a rate that—

(A) is determined under the State high
risk pool by considering the premium rates
charged by other health insurance issuers offering
health insurance coverage to individuals in
the insurance market served;

(B) is established using reasonable actuarial

 techniques; and

(C) reflects anticipated claims experience
 and expenses for the coverage involved.

(5) STATE.—The term “State” means any of
the 50 States or the District of Columbia.

SEC. 102. NO ANNUAL OR LIFETIME SPENDING CAPS.

Notwithstanding any other provision of law, a health
insurance issuer (including an entity licensed to sell insur-
ance with respect to a State or group health plan) may
not apply an annual or lifetime aggregate spending cap
on any health insurance coverage or plan offered by such
issuer.
SEC. 103. PREVENTING UNJUST CANCELLATION OF INSURANCE COVERAGE.

(a) Clarification Regarding Application of Guaranteed Renewability of Individual Health Insurance Coverage.—Section 2742 of the Public Health Service Act (42 U.S.C. 300gg–42), as restored by section 2, is amended—

(1) in its heading, by inserting “, Continuation in Force, Including Prohibition of Rescission,” after “Guaranteed Renewability”; and

(2) in subsection (a), by inserting “, including without rescission,” after “continue in force”; and

(3) in subsection (b)(2), by inserting before the period at the end the following: “, including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed”.

(b) Opportunity for Independent, External Third Party Review in Certain Cases.—Subpart 1 of part B of title XXVII of the Public Health Service Act, as restored by section 2, is amended by adding at the end the following new section:
“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.

“(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to nonrenew or not continue in force, including rescind, health insurance coverage for an individual in the individual market on the basis described in section 2742(b)(2) before such nonrenewal, discontinuation, or rescission, may take effect the issuer shall provide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

“(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply after the date of the enactment of this Act with respect to health insurance coverage issued before, on, or after such date.
DIVISION B—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Subtitle A—Enhanced Marketplace Pools

SEC. 201. RULES GOVERNING ENHANCED MARKETPLACE POOLS.

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

“PART 8—RULES GOVERNING ENHANCED MARKETPLACE POOLS

“SEC. 801. SMALL BUSINESS HEALTH PLANS.

“(a) In General.—For purposes of this part, the term ‘small business health plan’ means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

“(b) Sponsorship.—The sponsor of a group health plan is described in this subsection if such sponsor—
“(1) 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 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;

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

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

"SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZATIONS.

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

"(b) ADAPTATION OF STANDARDS.—In developing and promulgating regulations pursuant to subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, small business health plans, small and large employers, large and small insurance issuers, consumer representatives, and state insurance commissioners, shall—
“(1) adapt the standards of this part, to the maximum degree practicable, to assure balanced and comparable oversight standards for both small business health plans and alternative market pooling organizations;

“(2) permit the participation as alternative market pooling organizations unions, churches and other faith-based organizations, or other organizations composed of individuals and groups which may have little or no association with employment, provided however, that such alternative market pooling organizations meet, and continue meeting on an ongoing basis, to satisfy standards, rules, and requirements materially equivalent to those set forth in this part with respect to small business health plans;

“(3) conduct periodic verification of such compliance by alternative market pooling organizations, in consultation with the Secretary of Health and Human Services and the National Association of Insurance Commissioners, except that such periodic verification shall not materially impede market entry or participation as pooling entities comparable to that of small business health plans;

“(4) assure that consistent, clear, and regularly monitored standards are applied with respect to al-
ternative market pooling organizations to avert ma-
terial risk-selection within or among the composition
of such organizations;

“(5) the expedited and deemed certification pro-
cedures provided in section 805(d) shall not apply to
alternative market pooling organizations until sooner
of the promulgation of regulations under this sub-
section or the expiration of one year following enact-
ment of this Act; and

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

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

“(a) In General.—Not later than 6 months after
the date of enactment of this part, the applicable authority
shall prescribe by interim final rule a procedure under
which the applicable authority shall certify small business
health plans which apply for certification as meeting the
requirements of this part.

“(b) REQUIREMENTS APPLICABLE TO CERTIFIED
PLANS.—A small business 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).

“(c) REQUIREMENTS FOR CONTINUED CERTIF-
ICATION.—The applicable authority may provide by regula-
tion for continued certification of small business health
plans under this part. Such regulation shall provide for
the revocation of a certification if the applicable authority
finds that the small business health plan involved is failing
to comply with the requirements of this part.

“(d) EXPEDITED AND DEEMED CERTIFICATION.—

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

“(2) CIVIL PENALTY.—The Secretary may as-
sess a civil penalty against the board of trustees and
plan sponsor (jointly and severally) of a small busi-
ness health plan that is deemed certified under para-
graph (1) of up to $500,000 in the event the Sec-
retary determines that the application for certifi-
cation of such small business health plan was will-
fully or with gross negligence incomplete or inac-
curate.

“SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND

BOARDS OF TRUSTEES.

“(a) SPONSOR.—The requirements of this subsection
are met with respect to a small business 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 a small business
health plan if the following requirements are met:

“(1) FISCAL CONTROL.—The plan is operated,
pursuant to a plan document, by a board of trustees
which pursuant to a trust agreement 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 pro-
vided in clauses (ii) and (iii), the members
of the board of trustees are individuals se-
lected from individuals who are the owners,
officers, directors, or employees of the par-
ticipating 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 con-
stitute 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 PRO-
VIDERS OF MEDICAL CARE.—In the
case of a sponsor which is an associa-
tion whose membership consists pri-
marily of providers of medical care,
subclause (I) shall not apply in the
case of any service provider described
in subclause (I) who is a provider of
medical care under the plan.

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

“(B) SOLE AUTHORITY.—The board has
sole authority under the plan to approve appli-
cations for participation in the plan and to con-
tract with insurers.
“(c) Treatment of Franchises.—In the case of a group health plan which is established and maintained by a franchiser for a franchisor or for 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 franchisor were deemed to be the sponsor referred to in section 801(b) and each franchisee were deemed to be a member (of the sponsor) referred to in section 801(b); and

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

For purposes of this subsection the terms ‘franchisor’ and ‘franchisee’ shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

“Sec. 805. Participation and Coverage Requirements.

“(a) Covered Employers and Individuals.—The requirements of this subsection are met with respect to a small business 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, 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 dependents of individuals described in subparagraph (A).

“(b) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to a small business 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.

“(e) Prohibition of Discrimination Against Employers and Employees Eligible To Participate.—
The requirements of this subsection are met with respect to a small business 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) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; and

“(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.
“SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

“(a) In General.—The requirements of this section are met with respect to a small business health plan if the following requirements are met:

“(1) Contents of governing instruments.—

“(A) In general.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

“(i) 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)); and

“(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

“(B) Description of material provisions.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the ma-
terial benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

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

“(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged, subject to subparagraph (B) and the terms of this title.

“(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

“(i) setting contribution rates for the small business health plan based on the claims experience of the small business
health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

“(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXXI of the Public Health Service Act (relating to rating requirements), as added by subtitle B of title II of the Health Security for All Americans Act of 2010.

“(3) Exceptions regarding self-employed and large employers.—
“(A) Self-employed.—

“(i) In general.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

“(ii) Guarantee issue.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

“(B) Large employers.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for
large employers in the State in which such large
participating employers are located.

“(4) Regulatory requirements.—Such
other requirements as the applicable authority deter-
dines are necessary to carry out the purposes of this
part, which shall be prescribed by the applicable au-
thority by regulation.

“(b) Ability of small business health plans
to design benefit options.—Nothing in this part or
any provision of State law (as defined in section
514(c)(1)) shall be construed to preclude a small business
health plan or a health insurance issuer offering health
insurance coverage in connection with a small business
health plan from exercising its sole discretion in selecting
the specific benefits and services consisting of medical care
to be included as benefits under such plan or coverage,
except that such benefits and services must meet the terms
and specifications of part II of subtitle A of title XXXI
of the Public Health Service Act (relating to lower cost
plans), as added by subtitle B of title II of the Health

“(c) Domicile and non-domicile states.—
“(1) Domicile state.—Coverage shall be
issued to a small business health plan in the State
in which the sponsor’s principal place of business is
located.

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

“(A) TEMPORARY PREEMPTION.—If, upon
the expiration of the 90-day period following
the submission of a licensure application by
such insurer (that includes a certified copy of
an approved licensure application as submitted
by such insurer in the domicile State) to such
State, such State has not approved or denied
such application, such State’s health insurance
licensure laws shall be temporarily preempted
and the insurer shall be permitted to operate in
such State, subject to the following terms:

“(i) APPLICATION OF NON-DOMICILE
STATE LAW.—Except with respect to licen-
sure and with respect to the terms of sub-
title A of title XXXI of the Public Health
Service Act (relating to rating and benefits
as added by subtitle B of title II of the
Health Security for All Americans Act of 2010, the laws and authority of the non-domicile State shall remain in full force and effect.

“(ii) Revocation of preemption.—
The preemption of a non-domicile State’s health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

“(I) Approval or denial of application.—The approval of denial of an insurer’s licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

“(II) Determination of material violation.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXXI of
the Public Health Service Act (relating to rating and benefits added by subtitle B of title II of the Health Security for All Americans Act of 2010)) of such State.

“(B) NO PROHIBITION ON PROMOTION.—

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

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

“(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed
insurer in that State, even where such insurer
is not the insurer of such small business health
plan in the State in which such small business
health plan is domiciled.

"SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-
LATED REQUIREMENTS.

“(a) FILING FEE.—Under the procedure prescribed
pursuant to section 802(a), a small business 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 appropria-
tion Acts, for the sole purpose of administering the certifi-
cation procedures applicable with respect to small business
health plans.

“(b) INFORMATION TO BE INCLUDED IN APPLICA-
TION FOR CERTIFICATION.—An application for certifi-
cation under this part meets the requirements of this sec-
tion 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, health insurance issuer, and contract administrators and other service providers.

“(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless
written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

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

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

“(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;
“(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. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

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

“SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.

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

“(1) 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, or

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

“(2) Applicable authority.—The term ‘applicable authority’ means the Secretary of Labor, except that, in connection with any exercise of the Secretary’s authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

“(3) 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.

“(4) Group health plan.—The term ‘group health plan’ has the meaning provided in section
733(a)(1) (after applying subsection (b) of this section).

"(5) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

"(6) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided in section 733(b)(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) Medical Care.—The term ‘medical care’ has the meaning provided in section 733(a)(2).

“(9) Participating Employer.—The term ‘participating employer’ means, in connection with a small business 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.

“(10) Small Employer.—The term ‘small employer’ means, in connection with a group health
plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

“(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms ‘trade association’ and ‘professional association’ mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

“(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business 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—

“(1) 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

“(2) 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.

“(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small
business health plan shall not be deemed to be a plan
sponsor in applying requirements relating to coverage re-
newal.

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

(b) CONFORMING AMENDMENTS TO PREEMPTION
RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C.
1144(b)(6)), as restored by section 2, 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 a small business health plan which is certified under
part 8.”.

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

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

(B) in subsection (b)(5), by striking “sub-
section (a)” in subparagraph (A) and inserting
“subsection (a) of this section and subsections
(a)(2)(B) and (b) of section 805”, and by strik-
ing “subsection (a)” in subparagraph (B) and
inserting “subsection (a) of this section or sub-
section (a)(2)(B) or (b) of section 805”; (C) by redesignating subsection (d) as sub-
section (e); and (D) by inserting after subsection (e) 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 a
health insurance issuer from offering health insurance cov-
ere in connection with a small business health plan
which is certified under part 8.
“(2) In any case in which health insurance coverage
of any policy type is offered under a small business health
plan certified under part 8 to a participating employer op-
erating in such State, the provisions of this title shall su-
persede any and all laws of such State insofar as they may
establish rating and benefit requirements that would oth-
erwise apply to such coverage, provided the requirements
of subtitle A of title XXXI of the Public Health Service
Act (as added by title II of the Health Security for All
Americans Act of 2010) (concerning health plan rating
and benefits) are met.”.
(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)), as restored by section 2, is amended by adding at the end the following new sentence: “Such term also includes a person serving as the sponsor of a small business health plan under part 8.”.

(d) SAVINGS CLAUSE.—Section 731(c) of such Act, as restored by section 2, is amended by inserting “or part 8” after “this part”.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as restored by section 2, is amended by inserting after the item relating to section 734 the following new items:

“PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

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

SEC. 202. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136), as restored by section 2, is amended by adding at the end the following new subsection:
“(d) Consultation With States With Respect to Small Business Health Plans.—

“(1) Agreements with States.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business 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 small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

“(2) Recognition of Domicile State.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(e).”.

SEC. 203. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) Effective Date.—The amendments made by this subtitle shall take effect 12 months 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 6 months 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 808(a)(2) 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 trustees which has control over 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 or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.
DEFINITIONS.—For purposes of this subsection, the terms “group health plan”, “medical care”, and “participating employer” shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an “small business health plan” shall be deemed a reference to an arrangement referred to in this subsection.

Subtitle B—Market Relief

SEC. 204. MARKET RELIEF.

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

“TITLE XXXI—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

“SEC. 3101. GENERAL INSURANCE DEFINITIONS.

“In this title, the terms ‘health insurance coverage’, ‘health insurance issuer’, ‘group health plan’, and ‘individual health insurance’ shall have the meanings given such terms in section 2791.
“SEC. 3102. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

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

“Subtitle A—Market Relief

“PART I—RATING REQUIREMENTS

“SEC. 3111. DEFINITIONS.

“In this part:

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

“(2) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials des-
ignated by the State to enforce the insurance laws of such State.

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

“(4) ELIGIBLE INSURER.—The term ‘eligible insurer’ means a health insurance issuer that is licensed in a State and that—

“(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

“(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health
insurance coverage in that State consistent with
the Model Small Group Rating Rules, and pro-
vides with such notice a copy of any insurance
policy that it intends to offer in the State, its
most recent annual and quarterly financial re-
ports, and any other information required to be
filed with the insurance department of the State
(or other State agency); and

“(C) includes in the terms of the health ins-
surance coverage offered in nonadopting States
(including in the terms of any individual certifi-
cates that may be offered to individuals in con-
nection with such group health coverage) and
filed with the State pursuant to subparagraph
(B), a description in the insurer’s contract of
the Model Small Group Rating Rules and an af-
firmation that such Rules are included in the
terms of such contract.

“(5) Health Insurance Coverage.—The
term ‘health insurance coverage’ means any coverage
issued in the small group health insurance market,
except that such term shall not include excepted
benefits (as defined in section 2791(e)).

“(6) Index Rate.—The term ‘index rate’
means for each class of business with respect to the
rating period for small employers with similar case
characteristics, the arithmetic average of the applic-
cable base premium rate and the corresponding
highest premium rate.

“(7) Model Small Group Rating Rules.—
The term ‘Model Small Group Rating Rules’ means
the rules set forth in section 3112(a)(2).

“(8) Nonadopting State.—The term ‘non-
adopting State’ means a State that is not an adopt-
ing State.

“(9) Small Group Insurance Market.—The
term ‘small group insurance market’ shall have the
meaning given the term ‘small group market’ in sec-
tion 2791(e)(5).

“(10) State Law.—The term ‘State law’
means all laws, decisions, rules, regulations, or other
State actions (including actions by a State agency)
having the effect of law, of any State.

“(11) Variation Limits.—

“(A) Composite Variation Limit.—

“(i) In general.—The term ‘com-
posite variation limit’ means the total vari-
ation in premium rates charged by a
health insurance issuer in the small group
market as permitted under applicable State
law based on the following factors or case characteristics:

“(I) Age.

“(II) Duration of coverage.

“(III) Claims experience.

“(IV) Health status.

“(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

“(B) TOTAL VARIATION LIMIT.—The term ‘total variation limit’ means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 3112(a)(1)).

“SEC. 3112. RATING RULES.

“(a) Establishment of Minimum Standards for Premium Variations and Model Small Group Rating Rules.—Not later than 6 months after the date of
enactment of this title, the Secretary shall promulgate reg-
ulations establishing the following Minimum Standards "(1) MINIMUM STANDARDS FOR PREMIUM VARI-
ATIONS.—"

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

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

"(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

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

"(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following
provisions relating to premiums, except as pro-
vided for under subsection (b):

“(i) **Variation in Premium**

rates. — The plan may not vary premium
rates by more than the minimum stand-
ards provided for under paragraph (1).

“(ii) **Index Rate.** — The index rate
for a rating period for any class of busi-
ness shall not exceed the index rate for any
other class of business by more than 20
percent, excluding those classes of business
related to association groups under this
title.

“(iii) **Class of Businesses.** — With
respect to a class of business, the premium
rates charged during a rating period to
small employers with similar case charac-
teristics for the same or similar coverage
or the rates that could be charged to such
employers under the rating system for that
class of business, shall not vary from the
index rate by more than 25 percent of the
index rate under clause (ii).

“(iv) **Increases for New Rating**

periods. — The percentage increase in the
premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

“(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

“(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than 1 year, due to the claim experience, health status or duration of cov-
verage of the employees or dependents
of the small employer as determined
from the small employer carrier’s rate
manual for the class of business in-
volved.

“(III) Any adjustment due to
change in coverage or change in the
case characteristics of the small em-
ployer as determined from the small
employer carrier’s rate manual for the
class of business.

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

“(vi) PROHIBITION ON USE OF CER-
TAIN CASE CHARACTERISTIC.—A small em-
ployer carrier shall not utilize case charac-
teristics, other than those permitted under
paragraph (1)(C), without the prior ap-
proval of the applicable State authority.
“(vii) CONSISTENT APPLICATION OF
FACTORS.—Small employer carriers shall
apply rating factors, including case charac-
teristics, consistently with respect to all
small employers in a class of business.
Rating factors shall produce premiums for
identical groups which differ only by the
amounts attributable to plan design and do
not reflect differences due to the nature of
the groups assumed to select particular
health benefit plans.

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

“(ix) REQUIRE COMPLIANCE.—Pre-
mium rates for small business health ben-
efit plans shall comply with the require-
ments of this subsection notwithstanding
any assessments paid or payable by a small
employer carrier as required by a State’s
small employer carrier reinsurance pro-
gram.
“(B) Establishment of separate class of business.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

“(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

“(ii) The small employer carrier has acquired a class of business from another small employer carrier.

“(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

“(C) Limitation.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

“(D) Limitation on transfers.—A small employer carrier shall not transfer a
small employer involuntarily into or out of a
class of business. A small employer carrier shall
not offer to transfer a small employer into or
out of a class of business unless such offer is
made to transfer all small employers in the
class of business without regard to case charac-
teristics, claim experience, health status or du-
ration of coverage since issue.

“(b) Transitional Model Small Group Rating
Rules.—

“(1) In general.—Not later than 6 months
after the date of enactment of this title and to the
extent necessary to provide for a graduated transi-
tion to the minimum standards for premium vari-
ation as provided for in subsection (a)(1), the Sec-
retary, in consultation with the National Association
of Insurance Commissioners (NAIC), shall promul-
gate State-specific transitional small group rating
rules in accordance with this subsection, which shall
be applicable with respect to non-adopting States
and eligible insurers operating in such States for a
period of not to exceed 3 years from the date of the
promulgation of the minimum standards for pre-
mium variation pursuant to subsection (a).
“(2) Compliance with transitional model small group rating rules.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

“(3) Transitioning of old business.—

“(A) In general.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure
a stable and fair transition for old and new
market entrants.

“(B) PERIOD FOR OPERATION OF INDE-
pendent rating classes.—In developing the
special transition standards pursuant to sub-
paragraph (A), the Secretary shall permit a
carrier in a non-adopting State, at its option, to
maintain independent rating classes for old and
new business for a period of up to 5 years, with
the commencement of such 5-year period to
begin at such time, but not later than the date
that is 3 years after the date of enactment of
this title, as the carrier offers a book of busi-
ness meeting the minimum standards for pre-
mium variation provided for in subsection
(a)(1) or the transitional small group rating
rules under paragraph (1).

“(4) OTHER TRANSITIONAL AUTHORITY.—In
developing the transitional small group rating rules
under paragraph (1), the Secretary shall provide for
the application of the transitional small group rating
rules in transition States as the Secretary may de-
determine necessary for a an effective transition.

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

“(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of this title.

“SEC. 3113. APPLICATION AND PREEMPTION.

“(a) SUPERSEding of State Law.—

“(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

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

“(A) prohibit an eligible insurer from of-
fering, marketing, or implementing small group
health insurance coverage consistent with the
Model Small Group Rating Rules or transitional
model small group rating rules; or

“(B) have the effect of retaliating against
or otherwise punishing in any respect an eligible
insurer for offering, marketing, or imple-
menting small group health insurance coverage
consistent with the Model Small Group Rating
Rules or transitional model small group rating
rules.

“(b) SAVINGS CLAUSE AND CONSTRUCTION.—

“(1) NONAPPLICATION TO ADOPTING STATES.—
Subsection (a) shall not apply with respect to adopt-
ing states.

“(2) NONAPPLICATION TO CERTAIN INSUR-
ERS.—Subsection (a) shall not apply with respect to
insurers that do not qualify as eligible insurers that
offer small group health insurance coverage in a
nonadopting State.

“(3) NONAPPLICATION WHERE OBTAINING RE-
LIEF UNDER STATE LAW.—Subsection (a)(1) shall
not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

“(4) No effect on preemption.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

“(5) Preemption limited to rating.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

“(c) Effective date.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small
Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

"SEC. 3114. CIVIL ACTIONS AND JURISDICTION.

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

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

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

"(d) Expedited Review.—

"(1) District Court.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such
action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

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

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

“SEC. 3115. ONGOING REVIEW.

“Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Com-
missioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

**PART II—AFFORDABLE PLANS**

**SEC. 3121. DEFINITIONS.**

“In this part:

“(1) ADOPTING STATE.—The term ‘adopting State’ means a State that has enacted a law providing that small group, individual, and large group health insurers in such State may offer and sell products in accordance with the List of Required Benefits and the Terms of Application as provided for in section 3122(b).

“(2) ELIGIBLE INSURER.—The term ‘eligible insurer’ means a health insurance issuer that is licensed in a nonadopting State and that—

“(A) notifies the Secretary, not later than 30 days prior to the offering of coverage de-
scribed in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the List of Required Benefits and Terms of Application in a nonadapting State;

“(B) notifies the insurance department of a nonadapting State (or other applicable State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the List of Required Benefits and Terms of Application, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

“(C) includes in the terms of the health insurance coverage offered in nonadapting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer’s contract of
the List of Required Benefits and a description
of the Terms of Application, including a de-
scription of the benefits to be provided, and
that adherence to such standards is included as
a term of such contract.

“(3) Health insurance coverage.—The
term ‘health insurance coverage’ means any coverage
issued in the small group, individual, or large group
health insurance markets, including with respect to
small business health plans, except that such term
shall not include excepted benefits (as defined in sec-
tion 2791(c)).

“(4) List of required benefits.—The term
‘List of Required Benefits’ means the List issued
under section 3122(a).

“(5) Nonadopting state.—The term ‘non-
adopting State’ means a State that is not an adopt-
ing State.

“(6) State law.—The term ‘State law’ means
all laws, decisions, rules, regulations, or other State
actions (including actions by a State agency) having
the effect of law, of any State.

“(7) State provider freedom of choice
law.—The term ‘State Provider Freedom of Choice
Law’ means a State law requiring that a health in-
insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law.

“(8) TERMS OF APPLICATION.—The term ‘Terms of Application’ means terms provided under section 3122(a).

“SEC. 3122. OFFERING AFFORDABLE PLANS.

“(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the ‘List of Required Benefits’) of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group, individual, and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through small business health plans, the List of Required Benefits applicable to the small group market shall apply.

“(b) TERMS OF APPLICATION.—

“(1) STATE WITH MANDATES.—With respect to a State that has a covered benefit, service, or cat-
egory of provider mandate in effect that is covered
under the List of Required Benefits under sub-
section (a), such State mandate shall, subject to
paragraph (3) (concerning uniform application),
apply to a coverage plan or plan in, as applicable,
the small group, individual, or large group market or
through a small business health plan in such State.

“(2) States without mandates.—With re-
spect to a State that does not have a covered ben-
efit, service, or category of provider mandate in ef-
fect that is covered under the List of Required Ben-
efits under subsection (a), such mandate shall not
apply, as applicable, to a coverage plan or plan in
the small group, individual, or large group market or
through a small business health plan in such State.

“(3) Uniform application of laws.—

“(A) In general.—With respect to a
State described in paragraph (1), in applying a
covered benefit, service, or category of provider
mandate that is on the List of Required Bene-
fits under subsection (a) the State shall permit
a coverage plan or plan offered in the small
group, individual, or large group market or
through a small business health plan in such
State to apply such benefit, service, or category
of provider coverage in a manner consistent
with the manner in which such coverage is ap-
plied under one of the three most heavily sub-
scribed national health plans offered under the
Federal Employee Health Benefits Program
under chapter 89 of title 5, United States Code
(as determined by the Secretary in consultation
with the Director of the Office of Personnel
Management), and consistent with the Publica-
tion of Benefit Applications under subsection
(c). In the event a covered benefit, service, or
category of provider appearing in the List of
Required Benefits is not offered in one of the
three most heavily subscribed national health
plans offered under the Federal Employees
Health Benefits Program, such covered benefit,
service, or category of provider requirement
shall be applied in a manner consistent with the
manner in which such coverage is offered in the
remaining most heavily subscribed plan of the
remaining Federal Employees Health Benefits
Program plans, as determined by the Secretary,
in consultation with the Director of the Office
of Personnel Management.
“(B) Exception regarding state provider freedom of choice laws.—Notwithstanding subparagraph (A), in the event a category of provider mandate is included in the List of Covered Benefits, any State Provider Freedom of Choice Law (as defined in section 3121(7)) that is in effect in any State in which such category of provider mandate is in effect shall not be preempted, with respect to that category of provider, by this part.

“(c) Publication of benefit applications.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary, in consultation with the Director of the Office of Personnel Management, shall publish in the Federal Register a description of such covered benefits, services, and categories of providers covered in that calendar year by each of the three most heavily subscribed nationally available Federal Employee Health Benefits Plan options which are also included on the List of Required Benefits.

“(d) Effective dates.—

“(1) Small business health plans.—With respect to health insurance provided to participating employers of small business health plans, the re-
quirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

“(2) Non-association coverage.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

“(e) Updating of List of Required Benefits.—Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.

“SEC. 3123. APPLICATION AND PREEMPTION.

“(a) Superceding of State Law.—

“(1) In general.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market
as applied to an eligible insurer, or health insurance
coverage issued by an eligible insurer, including with
respect to coverage issued to a small business health
plan, in a nonadopting State.

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

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

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

“(b) SAVINGS CLAUSE AND CONSTRUCTION.—

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

“(2) NONAPPLICATION TO CERTAIN INSUR-
ERS.—Subsection (a) shall not apply with respect to
insurers that do not qualify as eligible insurers who
offer health insurance coverage in a nonadopting State.

“(3) Nonapplication where obtaining relief under state law.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

“(4) No effect on preemption.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

“(5) Preemption limited to benefits.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State mandates regarding covered benefits, services, or categories of providers that would otherwise apply to eligible insurers.
“SEC. 3124. CIVIL ACTIONS AND JURISDICTION."

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

“(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 3123.

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

“(d) EXPEDITED REVIEW.—

“(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.
“(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

“SEC. 3125. RULES OF CONSTRUCTION.

“(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

“(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that
would require reimbursements in violation of section 223(e)(2) of the Internal Revenue Code of 1986.”

**TITLE II—TARGETED EFFORTS TO EXPAND ACCESS**

**SEC. 211. EXTENDING COVERAGE OF DEPENDENTS.**

(a) **Employee Retirement Income Security Act of 1974.—**

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

“**SEC. 715. EXTENDING COVERAGE OF DEPENDENTS.**

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

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

•HR 3165 IH
(2) **Clerical Amendment.**—The table of contents of such Act is amended by inserting after the item relating to section 714 the following new item:

“Sec. 715. Extending coverage of dependents.”.

(b) **PHSA.**—Title XXVII of the Public Health Service Act, as restored by section 2, is amended by inserting after section 2707 the following new section:

**“SEC. 2708. EXTENDING COVERAGE OF DEPENDENTS.”**

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

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

(c) **IRC.**—

(1) **In General.**—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:
SEC. 9814. EXTENDING COVERAGE OF DEPENDENTS.

(a) In general.—In the case of a group health plan that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan shall continue to treat the individual as a dependent child without regard to the individual’s age until the individual turns 26 years of age.

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

(2) Clerical amendment.—The table of sections in such subchapter is amended by adding at the end the following new item:

“Sec. 9814. Extending coverage of dependents.”

(d) Effective date.—The amendments made by subsections (a), (b), and (c) shall apply to group health plans for plan years beginning more than 3 months after the date of the enactment of this Act and shall apply to individuals who are dependent children under a group health plan, or health insurance coverage offered in connection with such a plan, on or after such date.

(e) Adult dependents.—

(1) Exclusion of amounts expended for medical care.—The first sentence of section
105(b) of the Internal Revenue Code of 1986 (relating to amounts expended for medical care) is amended—

(A) by striking “and his dependents” and inserting “his dependents”; and

(B) by inserting before the period the following: “, and any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27”.

(2) Self-employed health insurance deduction.—Section 162(l)(1) of such Code is amended to read as follows:

“(1) Allowance of deduction.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for

“(A) the taxpayer,

“(B) the taxpayer’s spouse,

“(C) the taxpayer’s dependents, and

“(D) any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27.”.
(3) Coverage under self-employed deduction.—Section 162(l)(2)(B) of such Code is amended by inserting “, or any dependent, or individual described in subparagraph (D) of paragraph (1) with respect to,’” after “spouse of”.

(4) Sick and accident benefits provided to members of a voluntary employees’ beneficiary association and their dependents.—Section 501(c)(9) of such Code is amended by adding at the end the following new sentence: “For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term ‘dependent’ shall include any individual who is a child (as defined in section 152(f)(1)) of a member who as of the end of the calendar year has not attained age 27.”.

(5) Medical and other benefits for retired employees.—Section 401(h) of such Code is amended by adding at the end the following: “For purposes of this subsection, the term ‘dependent’ shall include any individual who is a child (as defined in section 152(f)(1)) of a retired employee who as of the end of the calendar year has not attained age 27.”.
SEC. 212. PROHIBITING PREEXISTING CONDITION EXCLUSIONS FOR ENROLLEES UNDER AGE 19.

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

(1) in the matter preceding paragraph (1), by inserting “and the last sentence of this subsection” after “subsection (d)”; and

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

“In the case of a participant or beneficiary who is under 19 years of age, a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”.

(b) ERISA.—Section 701(a) of the Employee Retirement Income Security Act of 1974, as restored by section 2, is amended—

(1) in the matter preceding paragraph (1), by inserting “and the last sentence of this subsection” after “subsection (d)”; and

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

“In the case of a participant or beneficiary who is under 19 years of age, a group health plan and a health insurance issuer offering group or individual health insurance
coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”.

(c) IRC.—Section 9801 of the Internal Revenue Code of 1986, as restored by section 2, is amended—

(1) in the matter preceding paragraph (1), by inserting “and the last sentence of this subsection” after “subsection (d)” ; and

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

“In the case of a participant or beneficiary who is under 19 years of age, a group health plan may not impose any preexisting condition exclusion with respect to such plan.”.

SEC. 213. HEALTH PLAN FINDERS.

(a) State Plan Finders.—Not later than 12 months after the date of the enactment of this Act, each State may contract with a private entity to develop and operate a plan finder website (referred to in this section as a “State plan finder”) which shall provide information to individuals in such State on plans of health insurance coverage that are available to individuals in such State (in this section referred to as a “health insurance plan”) . Such State may not operate a plan finder itself.

(b) Multi-State Plan Finders.—

(1) In general.—A private entity may operate a multi-State finder that operates under this section

...
in the States involved in the same manner as a State
plan finder would operate in a single State.

(2) **Sharing of Information.**—States shall
regulate the manner in which data is shared between
plan finders to ensure consistency and accuracy in
the information about health insurance plans con-
tained in such finders.

(c) **Requirements for Plan Finders.**—Each plan
finder shall meet the following requirements:

(1) The plan finder shall ensure that each
health insurance plan in the plan finder meets the
requirements for such plans under subsection (d).

(2) The plan finder shall present complete in-
formation on the costs and benefits of health insur-
ance plans (including information on monthly pre-
mium, copayments, and deductibles) in a uniform
manner that—

(A) uses the standard definitions developed
under paragraph (3); and

(B) is designed to allow consumers to eas-
ily compare such plans.

(3) The plan finder shall be available on the
Internet and accessible to all individuals in the State
or, in the case of a multi-State plan finder, in all
States covered by the multi-State plan finder.
(4) The plan finder shall allow consumers to search and sort data on the health insurance plans in the plan finder on criteria such as coverage of specific benefits (such as coverage of disease management services or pediatric care services), as well as data available on quality.

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

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

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

(8) Notwithstanding subsection (f)(1), the plan finder shall assist 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 infor-
information on Medicaid options, eligibility, and how to enroll.

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

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

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

(A) The health insurance plan shall be actuarially sound.

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

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

(D) The health insurance plan shall disclose—

(i) all financial arrangements involving the sale and purchase of health insur-
ance, such as the payment of fees and commissions; and

(ii) such arrangements may not be abusive.

(E) The health insurance plan shall maintain electronic health records that comply with the requirements of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) related to electronic health records.

(F) The health insurance plan shall make available to plan enrollees via the finder, whether by information provided to the finder or by a website link directing the enrollee from the finder to the health insurance plan website, data that includes the price and cost to the individual of services offered by a provider according to the terms and conditions of the health plan. Data described in this paragraph is not made public by the finder, only made available to the individual once enrolled in the health plan.

(e) Prohibitions.—

(1) Direct Enrollment.—The State plan finder may not directly enroll individuals in health insurance plans.
(2) Conflicts of Interest.—

(A) Companies.—A health insurance issuer offering a health insurance plan through a plan finder may not—

(i) be the private entity developing and maintaining a plan finder under subsections (a) and (b); or

(ii) have an ownership interest in such private entity or in the plan finder.

(B) Individuals.—An individual employed by a health insurance issuer offering a health insurance plan through a plan finder may not serve as a director or officer for—

(i) the private entity developing and maintaining a plan finder under subsections (a) and (b); or

(ii) the plan finder.

(f) Construction.—Nothing in this section shall be construed to allow the Secretary authority to regulate benefit packages or to prohibit health insurance brokers and agents from—

(1) utilizing the plan finder for any purpose; or

(2) marketing or offering health insurance products.
(g) **Plan Finder Defined.**—For purposes of this section, the term “plan finder” means a State plan finder under subsection (a) or a multi-State plan finder under subsection (b).

(h) **State Defined.**—In this section, the term “State” has the meaning given such term for purposes of title XIX of the Social Security Act.

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

**SEC. 221. INTERSTATE PURCHASING OF HEALTH INSURANCE.**

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

“PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

“SEC. 2795. DEFINITIONS.

“In this part:

“(1) **Primary State.**—The term ‘primary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State
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 re-
spect 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 insur-
ance 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).

“(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 the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

“(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 re-
quests with reasonable explanations regarding their use.

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

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

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

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

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

“(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.
“(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 insur-
ance in violation of laws requiring a license, cer-
tificate of authority or other legal authority for
the transaction of the business of insurance.

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

“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 re-
spect to the offering of coverage in any secondary State.

“(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
ONDARY STATE.—Except as provided in this section, a
health insurance issuer with respect to its offer, sale, rat-
ing (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 in-
directly, 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 doc-
uments or process;

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

“(i) the State insurance commissioner
of the primary State has not done an ex-
amination 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, re-
spectively, for the coverage concerned:

THIS POLICY IS ISSUED BY ________ AND
IS GOVERNED BY THE LAWS AND REGULA-
TIONS OF THE STATE OF ________, AND IT
HAS MET ALL THE LAWS OF THAT STATE
AS DETERMINED BY THAT STATE'S DE-
PARTMENT 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 BENE-
FITS MANDATED BY THE LAW OF THE
STATE OF ________. ADDITIONALLY, THIS
POLICY IS NOT SUBJECT TO ALL OF THE
CONSUMER PROTECTION LAWS OR RE-
STRICTIONS ON RATE CHANGES OF THE
STATE OF ________. AS WITH ALL INSUR-
ANCE 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 qualification 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 pri-
mary State; and

“(2) to the insurance commissioner of each sec-
ondary State in which it offers individual health in-
surance coverage, a copy of the issuer’s quarterly fi-
nancial statement submitted to the primary State,
which statement shall be certified by an independent
public accountant and contain a statement of opin-
ion 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 in-
surance; 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 Ad-
ministrative 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 sec-
tion 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 con-
strued 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 Fed-
eral 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 coverage 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
111

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

“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCED-
DURES.

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

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

“(2) in any case in which the requirements of
subparagraph (A) are not met with respect to the ei-
ther of such States, the issuer provides an inde-
pendent review mechanism substantially identical (as
determined by the applicable State authority of such
State) to that prescribed in the ‘Health Carrier Ex-
ternal 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 re-
viewer 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) Licenseure and Expertise.—Each inde-
dependent medical reviewer shall be a physician
(allopathic or osteopathic) or health care profes-
sional who—
“(A) is appropriately credentialed or licensed in 1 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 diag-
nosis, 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. 2799. 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 preexisting 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).
TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

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

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

“(v) a high deductible health plan if—

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

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

“(III) the account beneficiary demonstrates, using procedures deemed appropriate by the Secretary, that after payment of the premium for such insurance the balance in the health savings account is at least twice the minimum deductible in ef-
fect under subsection (c)(2)(A)(i) which is applicable to such plan.”

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

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

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

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

(a) In General.—Subsection (d) of section 223 of the Internal Revenue Code of 1986, as restored by section 2, is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:
“(4) Certain medical expenses incurred before establishment of account treated as qualified.—

“(A) In general.—For purposes of paragraph (2), an expense shall not fail to be treated as a qualified medical expense solely because such expense was incurred before the establishment of the health savings account if such expense was incurred during the 60-day period beginning on the date on which the high deductible health plan is first effective.

“(B) Special rules.—For purposes of subparagraph (A)—

“(i) an individual shall be treated as an eligible individual for any portion of a month for which the individual is described in subsection (c)(1), determined without regard to whether the individual is covered under a high deductible health plan on the 1st day of such month, and

“(ii) the effective date of the health savings account is deemed to be the date on which the high deductible health plan is first effective after the date of the enactment of this paragraph.”.
(b) Effective Date.—The amendment made by this section shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years beginning after such date.

TITLE V—TAX-RELATED HEALTH INCENTIVES

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

(a) In General.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 242. 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 for individuals) 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) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term ‘qualified health insurance’ means insurance which constitutes medical care, other than insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c).

(c) 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 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, 2010.

**DIVISION C—Enacting Real Medical Liability Reform**

**Sec. 301. Cap on Non-Economic Damages Against Health Care Practitioners.**

When an individual is injured or dies as the result of health care, a person entitled to non-economic damages may not recover, from the class of liable health care practitioners (regardless of the theory of liability), more than $250,000 such damages.
SEC. 302. CAP ON NON-ECONOMIC DAMAGES AGAINST HEALTH CARE INSTITUTIONS.

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

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

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

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

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

(b) Total Damages Defined.—In this section, the term “total damages” includes compensatory damages, punitive damages, statutory damages, and any other type of damages.

(e) Adjustment for Inflation.—For each calendar year after the calendar year of the enactment of this Act, the dollar amount referred to in subsection (a)
shall be adjusted to reflect changes in the Consumer Price Index of the Bureau of Labor Statistics of the Department of Labor. The adjustment shall be based on the relationship between—

(1) the Consumer Price Index data most recently published as of January 1 of the calendar year of the enactment of this Act; and

(2) the Consumer Price Index data most recently published as of January 1 of the calendar year concerned.

(d) Applicability of Adjustment.—The dollar amount that applies to a recovery is the dollar amount for the calendar year during which the amount of the recovery is made final.

SEC. 304. LIMITATION OF INSURER LIABILITY WHEN INSURER REJECTS CERTAIN SETTLEMENT OFFERS.

In a civil action, to the extent the civil action seeks damages for the injury or death of an individual as the result of health care, when the insurer of a health care practitioner or health care institution rejects a reasonable settlement offer within policy limits, the insurer is not, by reason of that rejection, liable for damages in an amount that exceeds the liability of the insured.
SEC. 305. MANDATORY JURY INSTRUCTION ON CAP ON DAMAGES.

In a civil action tried to a jury, to the extent the civil action seeks damages for the injury or death of an individual as the result of health care, the court shall instruct the jury that the jury is not to consider whether, or to what extent, a limitation on damages applies.

SEC. 306. DETERMINATION OF NEGLIGENCE; MANDATORY JURY INSTRUCTION.

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

(b) Mandatory Jury Instruction.—In a civil action tried to a jury, to the extent the civil action seeks damages for the injury or death of an individual as the result of health care and alleges liability for negligence, the court shall instruct the jury as provided in subsection (a).

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

(a) Service Required.—To the extent a pleading filed in a civil action seeks damages against a health care practitioner for the injury or death of an individual as the result of health care, the party filing the pleading shall, not later than 120 days after the date on which the plead-
ing was filed, serve on each party against whom such dam-
ages are sought a qualified expert report.

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

(1) includes a curriculum vitae for that expert;

and

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

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

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

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

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

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

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

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

(A) be offered by any party as evidence;

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

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

(2) VIOLATIONS.—

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

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

SEC. 308. EXPERT OPINIONS RELATING TO PHYSICIANS

MAY BE PROVIDED ONLY BY ACTIVELY PRACTICING PHYSICIANS.

(a) IN GENERAL.—A physician-related opinion may be provided only by an actively practicing physician who is determined by the court to be qualified on the basis of training and experience to render that opinion.
(b) CONSIDERATIONS REQUIRED.—In determining whether an actively practicing physician is qualified under subsection (a), the court shall, except on good cause shown, consider whether that physician is board-certified, or has other substantial training, in an area of medical practice relevant to the health care to which the opinion relates.

(c) DEFINITIONS.—In this section:

(1) The term “actively practicing physician” means an individual who—

(A) is licensed to practice medicine in the United States or, if the individual is a defendant providing a physician-related opinion with respect to the health care provided by that defendant, is a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association;

(B) is practicing medicine when the opinion is rendered, or was practicing medicine when the health care was provided; and

(C) has knowledge of the accepted standards of care for the health care to which the opinion relates.
(2) The term “physician-related opinion” means an expert opinion as to any one or more of the following:

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

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

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

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

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

(a) IN GENERAL.—When future damages are awarded against a health care practitioner to a person for the injury or death of an individual as a result of health care, and the present value of those future damages is $100,000 or more, that health care practitioner may move that the court order payment on a periodic or accrual basis of those damages. On such a motion, the court—
(1) shall order that payment be made on an ac-
crual basis of future damages described in sub-
section (b)(1); and

(2) may order that payment be made on a peri-
odic or accrual basis of any other future damages
that the court considers appropriate.

(b) FUTURE DAMAGES DEFINED.—In this section,
the term “future damages” means—

(1) the future costs of medical, health care, or
custodial services;

(2) noneconomic damages, such as pain and
suffering or loss of consortium;

(3) loss of future earnings; and

(4) any other damages incurred after the award
is made.

SEC. 310. UNANIMOUS JURY REQUIRED FOR PUNITIVE OR
EXEMPLARY DAMAGES.

When an individual is injured or dies as the result
of health care, a jury may not award punitive or exemplary
damages against a health care practitioner or health care
institution unless the jury is unanimous with regard to
both the liability of that party for such damages and the
amount of the award of such damages.
SEC. 311. PROPORTIONATE LIABILITY.

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

SEC. 312. DEFENSE-INITIATED SETTLEMENT PROCESS.

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

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

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

(2) states the terms of settlement; and

(3) states the deadline within which the offer must be accepted.
(c) **Effect of Offer.**—If the offeree of a qualified settlement offer does not accept that offer, and thereafter receives a judgment at trial that, as between the offeror and the offeree, is significantly less favorable than the terms of settlement in that offer, that offeree is responsible for those litigation costs reasonably incurred, after the deadline stated in the offer, by the offeror to respond to the claims of the offeree.

(d) **Litigation Costs Defined.**—In this section, the term “litigation costs” include court costs, filing fees, expert witness fees, attorney fees, and any other costs directly related to carrying out the litigation.

(e) **Significantly Less Favorable Defined.**—For purposes of this section, a judgment is significantly less favorable than the terms of settlement if—

1. in the case of an offeree seeking damages, the offeree’s award at trial is less than 80 percent of the value of the terms of settlement; and
2. in the case of an offeree against whom damages are sought, the offeror’s award at trial is more than 120 percent of the value of the terms of settlement.
SEC. 313. STATUTE OF LIMITATIONS; STATUTE OF REPOSE.

(a) Statute of Limitations.—When an individual is injured or dies as the result of health care, the statute of limitations shall be as follows:

(1) Individuals of Age 12 and Over.—If the individual has attained the age of 12 years, the claim must be brought either—

(A) within 2 years after the negligence occurred; or

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

(2) Individuals Under Age 12.—If the individual has not attained the age of 12 years, the claim must be brought before the individual attains the age of 14 years.

(b) Statute of Repose.—When an individual is injured or dies as the result of health care, the statute of repose shall be as follows: The claim must be brought within 10 years after the act or omission on which the claim is based is completed.

(c) Tolling.—

(1) Statute of Limitations.—The statute of limitations required by subsection (a) may be tolled if applicable law so provides, except that it may not be tolled on the basis of minority.
(2) Statute of Repose.—The statute of repose required by subsection (b) may not be tolled for any reason.

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

(a) Willful or Wanton Negligence Required.—A health care practitioner or health care institution that provides emergency health care on a Good Samaritan basis is not liable for damages caused by that care except for willful or wanton negligence or more culpable misconduct.

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

SEC. 315. DEFINITIONS.

In this division:

(1) Health care institution.—The term “health care institution” includes institutions such as—

(A) an ambulatory surgical center;

(B) an assisted living facility;
(C) an emergency medical services provider;

(D) a home health agency;

(E) a hospice;

(F) a hospital;

(G) a hospital system;

(H) an intermediate care facility for the mentally retarded;

(I) a nursing home; and

(J) an end stage renal disease facility.

(2) HEALTH CARE PRACTITIONER.—The term “health care practitioner” includes a physician and a physician entity.

(3) PHYSICIAN ENTITY.—The term “physician entity” includes—

(A) a partnership or limited liability partnership created by a group of physicians;

(B) a company created by physicians; and

(C) a nonprofit health corporation whose board is composed of physicians.
DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 401. RULE OF CONSTRUCTION.

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

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

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

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

SEC. 501. INCENTIVES FOR PREVENTION AND WELLNESS PROGRAMS.

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

(1) IN GENERAL.—Section 702(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)(2)), as restored by section 2, is
amended by adding after and below subparagraph (B) the following:

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

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

(b) Conforming amendments to PHSA.—

(1) Group market rules.—

(A) In general.—Section 2702(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(2)), as restored by section 2, is amended by adding after and below subparagraph (B) the following:

“In applying subparagraph (B), a group health plan (or a health insurance issuer with respect to health insurance coverage) may vary premiums and cost-sharing by up to 50 percent of the value of the benefits under the plan (or coverage) based on participation in a standards-based wellness program.”.
(B) **Effective date.**—The amendment made by subparagraph (A) shall apply to plan years beginning more than 1 year after the date of the enactment of this Act.

(2) **Individual market rules relating to guaranteed availability.**—

(A) **In general.**—Section 2741(f) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(2)), as restored by section 2, is amended by adding after and below paragraph (1) the following:

“In applying paragraph (2), a health insurance issuer may vary premiums and cost-sharing under health insurance coverage by up to 50 percent of the value of the benefits under the coverage based on participation in a standards-based wellness program.”.

(B) **Effective date.**—The amendment made by paragraph (1) shall apply to health insurance coverage offered or renewed on and after the date that is 1 year after the date of the enactment of this Act.

(c) **Conforming amendments to IRC.**—

(1) **In general.**—Section 9802(b)(2) of the Internal Revenue Code of 1986, as restored by sec-
tion 2, is amended by adding after and below sub-
paragraph (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 bene-
fits under the plan (or coverage) based on participa-
tion in a standards-based wellness program.”.

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

DIVISION F—PROTECTING TAXPAYERS

SEC. 601. PERMANENTLY PROHIBITING TAXPAYER FUNDED

ABORTIONS AND ENSURING CONSCIENCE

PROTECTIONS.

Title 1 of the United States Code is amended by add-
ing at the end the following new chapter:
“CHAPTER 4—PERMANENTLY PROHIBITING TAXPAYER FUNDED ABORTIONS AND ENSURING CONSCIENCE PROTECTIONS

“SEC. 301. PROHIBITION ON FUNDING FOR ABORTIONS.

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

“SEC. 302. PROHIBITION ON FUNDING FOR HEALTH BENEFITS PLANS THAT COVER ABORTION.

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

“SEC. 303. TREATMENT OF ABORTIONS RELATED TO RAPE, INCEST, OR PRESERVING THE LIFE OF THE MOTHER.

“The limitations established in sections 301 and 302 shall not apply to an abortion—

“(1) if the pregnancy is the result of an act of rape or incest; or

“(2) 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 per-
formed, including a life-endangering physical condi-
tion caused by or arising from the pregnancy itself. 

“SEC. 304. CONSTRUCTION RELATING TO SUPPLEMENTAL 
COVERAGE.

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

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

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

•HR 3165 IH
a federally subsidized program, including a State’s or locality’s contribution of Medicaid matching funds.

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

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

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

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

(a) MEDICARE.—

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

(2) 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.

(3) 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 payer provisions, including recoupment of credit balances.

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

“(aa) ENFORCEMENT OF PAYER OF LAST RESORT PROVISIONS.—

“(1) SUBMISSION OF STATE PLAN AMENDMENT.—Each State shall submit, not later than 1
year after the date of the enactment of this subsection, a State plan amendment that details how the State will become fully compliant with the requirements of section 1902(a)(25).

“(2) BONUS FOR COMPLIANCE.—If a State submits a timely State plan amendment under paragraph (1) that the Secretary determines provides for full compliance of the State with the requirements of section 1902(a)(25), the Secretary shall provide for an additional payment to the State of $1,000,000. If a State certifies, to the Secretary’s satisfaction, that it is already fully compliant with such requirements, such amount shall be increased to $2,000,000.

“(3) REDUCTION FOR NONCOMPLIANCE.—If a State does not submit such an amendment, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title by 1 percentage point until the State submits such an amendment.

“(4) ONGOING REDUCTION.—If at any time the Secretary determines that a State is not in compliance with section 1902(a)(25), regardless of the status of the State’s submission of a State plan amendment under this subsection or previous determinations of compliance such requirements, the Secretary
shall reduce the Federal medical assistance percentage otherwise applicable under this title for the State by 1 percentage point during the period of non-compliance as determined by the Secretary.”.

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

(a) Protecting Against the Fraudulent Use of Medicare Provider Numbers.—Subject to subsection (c)(2)—

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

(2) Application fees.—The Secretary shall impose an application charge on such a provider or supplier in order to cover the Secretary’s costs in performing the screening required under paragraph
(1) and that is revenue neutral to the Federal government.

(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 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 of Health and Human Services 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.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(2) CONDITION.—The provisions of paragraphs (1) and (2) of subsection (a) shall not apply unless
and until funds are appropriated to carry out such provisions.

SEC. 604. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

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

(b) IMPROVED INFORMATION SYSTEMS.—

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

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

(e) 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 Databases.—The Secretary shall consolidate and expand into a centralized database
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 relationships, 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 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.