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112TH CONGRESS
2D SESSION

H. R. 4224

To repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, to amend the Internal Revenue Code of 1986 to repeal the percentage floor on medical expense deductions, expand the use of tax-preferred health care accounts, and establish a charity care credit, to amend the Social Security Act to create a Medicare Premium Assistance Program and reform EMTALA requirements, and to amend the Public Health Service Act to provide for cooperative governing of individual and group health insurance coverage offered in interstate commerce.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 2012

Mr. BROUN of Georgia 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, the Judiciary, Natural Resources, Rules, Appropriations, and House Administration, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, to amend the Internal Revenue Code of 1986 to repeal the percentage floor on medical expense deductions, expand the use of tax-preferred health care accounts, and establish a charity care credit, to amend the Social Security Act to create a Medicare Premium Assistance Program and reform EMTALA requirements,

and to amend the Public Health Service Act to provide for cooperative governing of individual and group health insurance coverage offered in interstate commerce.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; CONSTRUCTION.

(a) SHORT TITLE.—This Act may be cited as the ''Offering Patients True Individualized Options Now Act of 2012'' or the ''OPTION Act of 2012''.

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

(c) CONSTRUCTION.—Nothing in this Act shall be construed to preclude or prohibit a health care provider or health insurance issuer from publicly disclosing any pricing of services provided or covered.

TITLE I—REPEAL OF PPACA AND HCERA

SEC. 101. REPEAL OF PPACA AND HCERA.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 are each repealed, effective as of the respective date of enactment of each such Act, and the provisions of law amended or repealed by such Acts are restored or revived as if such Acts had not been enacted.

TITLE II—HEALTH CARE TAX REFORM

Subtitle A—HSA Reform

SEC. 201. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN REQUIREMENT.

(a) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986 is amended by striking subsection (c)

and redesignating subsections (d) through (h) as subsections (c) through (g), respectively.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 223 of such Code is amended to read as follows:

''(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction for a taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.''.

(2) Subsection (b) of section 223 of such Code is amended by striking paragraph (8).

(3) Subparagraph (A) of section 223(c)(1) of the Internal Revenue Code of 1986 (as redesignated by subsection (b)(1)) is amended—

(A) by striking ''subsection (f)(5)'' and inserting ''subsection (e)(5)'', and

(B) in clause (ii)—

(i) by striking ''the sum of—'' and all that follows and inserting ''the dollar amount in effect under subsection (b)(1).''.

(4) Section 223(f)(1) of such Code (as redesignated by subsection (b)(1)) is amended by striking ''Each dollar amount in subsections (b)(2) and (c)(2)(A)'' and inserting ''In the case of a taxable

year beginning after December 31, 2010, each dollar amount in subsection (b)(1)''.

(5) Section 26(b)(U) of such Code is amended by striking ''section 223(f)(4)'' and inserting ''section 223(e)(4)''.

(6) Sections 35(g)(3), 220(f)(5)(A), 848(e)(1)(v), 4973(a)(5), and 6051(a)(12) of such Code are each amended by striking ''section 223(d)'' each place it appears and inserting ''section 223(e)''.

(7) Section 106(d)(1) of such Code is amended—

(A) by striking ''who is an eligible individual (as defined in section 223(e)(1))'', and

(B) by striking ''section 223(d)'' and inserting ''section 223(e)''.

(8) Section 408(d)(9) of such Code is amended—

(A) in subparagraph (A) by striking ''who is an eligible individual (as defined in section 223(e)) and'', and

(B) in subparagraph (C) by striking ''computed on the basis of the type of coverage under the high deductible health plan covering the individual at the time of the qualified HSA funding distribution''.

(9) Section 877A(g)(6) of such Code is amended by striking ''223(f)(4)'' and inserting ''223(e)(4)''.

(10) Section 4973(g) of such Code is amended—

(A) by striking ''section 223(d)'' and inserting ''section 223(c)'',

(B) in paragraph (2), by striking ''section 223(f)(2)'' and inserting ''section 223(e)(2)'', and

(C) by striking ''section 223(f)(3)'' and inserting ''section 223(e)(3)''.

(11) Section 4975 of such Code is amended—

(A) in subsection (c)(6)—

(i) by striking ''section 223(d)'' and inserting ''section 223(c)'', and

(ii) by striking ''section 223(e)(2)'' and inserting ''section 223(d)(2)'', and

(B) in subsection (e)(1)(E), by striking ''section 223(d)'' and inserting ''section 223(c)''.

(12) Section 6693(a)(2)(C) of such Code is amended by striking ''section 223(h)'' and inserting ''section 223(g)''.

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

SEC. 202. INCREASE IN DEDUCTIBLE HSA CONTRIBUTION LIMITATIONS.

(a) IN GENERAL.—Paragraph (1) of section 223(b) of the Internal Revenue Code of 1986 is amended by striking ''the sum of the monthly'' and all that follows through ''eligible individual'' and inserting ''$10,000 ($20,000 in the case of a joint return)''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (b) of such Code is amended by striking paragraphs (2), (3), and (5) and by redesignating paragraphs (4), (6), and (7) as paragraphs (2), (3), and (4), respectively.

(2) Paragraph (2) of section 223(b) of such Code (as redesignated by paragraph (1)) is amended by striking the last sentence.

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

SEC. 203. MEDICARE ELIGIBLE INDIVIDUALS ELIGIBLE TO CONTRIBUTE TO HSA.

(a) Subsection (b) of section 223 of the Internal Revenue Code of 1986 is amended by striking paragraph (7).

(b) Paragraph (1) of section 223(c) of such Code is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INDIVIDUALS ENTITLED TO BENEFITS UNDER MEDICARE.—In the case of an individual—

''(i) who is entitled to benefits under title XVIII of the Social Security Act, and

''(ii) with respect to whom a health savings account is established in a month before the first month such individual is entitled to such benefits,

such individual shall be deemed to be an eligible individual.''.

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

SEC. 204. HSA ROLLOVER TO MEDICARE ADVANTAGE MSA.

(a) IN GENERAL.—Paragraph (2) of section 138(b) of the Internal Revenue Code of 1986 is amended by striking ''or'' at the end of subparagraph (A), by adding ''or'' at the end of subparagraph (C), and by adding at the end the following new subparagraph:

''(C) a HSA rollover contribution described in subsection (d)(5),''.

(b) HSA ROLLOVER CONTRIBUTION.—Subsection (c) of section 138 of such Code is amended by adding at the end the following new paragraph:

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirement of subparagraphs (A) and (B).

''(A) IN GENERAL.—The requirements of this subparagraph are met in the case of an amount paid or distributed from a health savings to the account beneficiary to the extent the amount is received is paid into a Medicare Advantage MSA of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of section 223(f)(5)(A).''.

(c) CONFORMING AMENDMENT.—Subparagraph (A) of section 223(f)(5) of such Code is amended by inserting ''or Medicare Advantage MSA'' after ''into a health savings account''.

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

SEC. 205. REPEAL OF ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (f) of section 223 of the Internal Revenue Code of 1986 is amended by striking paragraph (4) and redesignating paragraphs (5), (6), and (7) and paragraphs (4), (5), and (6), respectively.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 25(b) of such Code is amended by striking subparagraph (U) and by redesignating subparagraphs (V), (W), and (X) as subparagraphs (U), (V), and (W).

(2) Subparagraph (C) of section 106(e)(4) of such Code is amended by striking ''223(f)(5)'' and inserting ''223(f)(4)''.

(3) Paragraph (6) of section 877A(g) of such Code is amended by striking ''223(f)(4),''.

(4) Paragraph (1) of section 4973(g) of such Code is amended by striking ''223(f)(5)'' and inserting ''223(f)(4)''.

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

Subtitle B—Other Health Care Tax Reform

SEC. 206. ELIMINATION OF 7.5-PERCENT FLOOR ON MEDICAL EXPENSE DEDUCTIONS.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking '', to the extent that such expenses exceed 7.5 percent of adjusted gross income''.

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 56(b) of such Code is amended by striking subparagraph (B).

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

SEC. 207. REPEAL OF PRESCRIBED DRUG LIMITATION ON CERTAIN TAX BENEFITS FOR MEDICAL EXPENSES.

(a) DEDUCTION FOR MEDICAL EXPENSES.—

(1) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 is amended by striking subsection (b).

(2) CONFORMING AMENDMENT.—Subsection (d) of section 213 of such Code is amended by striking paragraph (3).

(b) TREATMENT OF REIMBURSEMENTS UNDER ACCIDENT OR HEALTH PLANS.—Section 106 of such Code is amended by striking subsection (f).

(c) HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) of section 223(d)(2) of such Code is amended by striking the last sentence thereof.

(d) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of such Code is amended by striking the last sentence thereof.

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

SEC. 208. REPEAL OF 2-PERCENT MISCELLANEOUS ITEMIZED DEDUCTION FLOOR FOR MEDICAL EXPENSE DEDUCTIONS.

(a) IN GENERAL.—Subsection (b) of section 67 of the Internal Revenue Code of 1986 is amended by striking paragraph (5).

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

SEC. 209. CHARITY CARE CREDIT.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25D the following new section:

"SEC. 25E. CHARITY CARE CREDIT.

''(a) ALLOWANCE OF CREDIT.—In the case of a physician, there shall be allowed as a credit against the tax imposed by this chapter for a taxable year the amount determined in accordance with the following table:

"If the physician has provided during such taxable year:.	**The amount of the credit is:**
At least 25 but less than 30 qualified hours of charity care.	$2,000.
At least 30 but less than 35 qualified hours of charity care.	$2,400.
At least 35 but less than 40 qualified hours of charity care.	$2,800.
At least 40 but less than 45 qualified hours of charity care.	$3,200.
At least 45 but less than 50 qualified hours of charity care.	$3,600.
At least 50 but less than 55 qualified hours of charity care.	$4,000.
At least 55 but less than 60 qualified hours of charity care.	$4,400.
At least 60 but less than 65 qualified hours of charity care.	$4,800.
At least 65 but less than 70 qualified hours of charity care.	$5,200.
At least 70 but less than 75 qualified hours of charity care.	$5,600.
At least 75 but less than 80 qualified hours of charity care.	$6,000.

At least 80 but less than 85 qualified hours of charity care.	$6,400.
At least 85 but less than 90 qualified hours of charity care.	$6,800.
At least 90 but less than 95 qualified hours of charity care.	$7,200.
At least 95 but less than 100 qualified hours of charity care.	$7,600.
At least 100 hours of charity care	$8,000.

''(b) QUALIFIED HOURS OF CHARITY CARE.—For purposes of this section—

''(1) QUALIFIED HOURS OF CHARITY CARE.—The term 'qualified hours of charity care' means the hours that a physician provides medical care (as defined in section 213(d)(1)(A)) on a volunteer or pro bono basis.

''(2) PHYSICIAN.—The term 'physician' has the meaning given to such term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).''.

(b) CONFORMING AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Charity care credit.''.

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

SEC. 210. COBRA CONTINUATION COVERAGE EXTENDED.

(a) UNDER IRC.—Subparagraph (B) of section 4980B(f)(2) of the Internal Revenue Code of 1986 is

amended by striking clauses (i) and (v) and by redesignating clauses (ii), (iii), and (iv) as clauses (i), (ii), and (iii), respectively.

(b) UNDER ERISA.—Paragraph (2) of section 602 of the Employee Retirement Income Security Act of 2009 (29 U.S.C. 1162) is amended by striking subparagraphs (A) and (E) and by redesignating subparagraphs (B), (C), and (D) as subparagraphs (A), (B), and (C), respectively.

(c) UNDER PHSA.—Paragraph (2) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended by striking subparagraphs (A) and (E) and by redesignating subparagraphs (B), (C), and (D) as subparagraphs (A), (B), and (C), respectively.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after the date of the enactment of this Act.

SEC. 211. HSA CHARITABLE CONTRIBUTIONS.

(a) IN GENERAL.—Subsection (f) of section 223 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(9) DISTRIBUTIONS FOR CHARITABLE PURPOSES.—For purposes of this subsection—

"(A) IN GENERAL.—Paragraph (2) shall not apply to any qualified charitable distributions with respect to a taxpayer made during any taxable year.

"(B) QUALIFIED CHARITABLE DISTRIBUTION.—For purposes of this paragraph, the term 'qualified charitable distribution' means any distribution from a health savings account which is made directly by the trustee to an organization described in section 170(b)(1)(A) (other than any organization described in section 509(a)(3) or any fund or account described in section 4966(d)(2)). A distribution shall be treated as a qualified charitable distribution only to the extent that the distribution would be includible in gross income without regard to subparagraph (A).

"(C) CONTRIBUTIONS MUST BE OTHERWISE DEDUCTIBLE.—For purposes of this paragraph, a distribution to an organization described in subparagraph (B) shall be treated as a qualified charitable distribution only if a deduction for the entire distribution would be allowable under section 170 (determined without

regard to subsection (b) thereof and this paragraph).

''(D) DENIAL OF DEDUCTION.—Qualified charitable distributions which are not includible in gross income pursuant to subparagraph (A) shall not be taken into account in determining the deduction under section 170.''.

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

TITLE III—MEDICARE PREMIUM ASSISTANCE PROGRAM

SEC. 301. REPLACEMENT OF MEDICARE PART A ENTITLEMENT WITH MEDICARE REFORM PREMIUM ASSISTANCE PROGRAM.

(a) IN GENERAL.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended by adding at the end the following new subsections:

''(k) REPLACEMENT OF ENTITLEMENT WITH PREMIUM ASSISTANCE PROGRAM.—

''(1) IN GENERAL.—Notwithstanding the previous provisions of this section, beginning the first January 1 after the date of the enactment of the Offering Patients True Individualized Options Act of

2011, the Secretary shall establish procedures under which—

"(A) in the case of an individual who, but for the application of this paragraph, would otherwise become entitled under subsection (a) on or after such January 1 to benefits under part A of title XVIII, subject to paragraph (4), the individual shall in lieu of such entitlement be automatically enrolled in the Medicare Reform Premium Assistance Program established under subsection (l); and

"(B) in the case of an individual who before such January 1 is entitled under subsection (a) to benefits under part A of title XVIII, the individual may in lieu of such entitlement elect on or after such January 1 to enroll in the Medicare Reform Premium Assistance Program established under subsection (l).

"(2) TREATMENT UNDER THE INTERNAL REVENUE CODE OF 1986.—An individual who is enrolled under the Medicare Reform Premium Assistance Program under paragraph (1) shall not be treated as entitled to benefits under title XVIII for purposes of section 223(b)(7) of the Internal Revenue Code of 1986.

"(3) INELIGIBILITY FOR PART B OR D BENEFITS.—An individual shall not be eligible for benefits under part B or D of title XVIII once the individual is enrolled in the Medicare Reform Premium Assistance Program under paragraph (1).

"(4) OPT OUT.—

"(A) IN GENERAL.—Any individual who is otherwise eligible for automatic enrollment in the Medicare Reform Premium Assistance Program under paragraph (1)(A) may elect (in such form and manner as may be specified by the Secretary of Health and Human Services) to not be so enrolled.

"(B) INDIVIDUALS ELECTING TO OPT OUT NOT TREATED AS ENTITLED TO MEDICARE BENEFITS.—In the case of an individual who makes an election under subparagraph (A)—

"(i) such individual shall not be eligible for benefits under part A of title XVIII; and

"(ii) the provisions of paragraphs (2) and (3) shall apply to such individual in the same manner as such paragraphs apply to an individual enrolled under the Medi-

care Reform Premium Assistance Program under paragraph (1).

''(l) MEDICARE REFORM PREMIUM ASSISTANCE.—

''(1) ESTABLISHMENT OF PREMIUM ASSISTANCE PROGRAM.—The Secretary shall establish a program to be known as the Medicare Reform Premium Assistance Program (in this subsection referred to as the 'premium assistance program') consistent with this subsection.

''(2) AUTOMATIC ENROLLMENT.—An individual otherwise entitled under subsection (a) to benefits under part A of title XVIII shall, subject to subsection (k)(4), be enrolled in the premium assistance program for the period during which such individual would otherwise be so entitled to benefits.

''(3) AMOUNT OF PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Subject to clause (ii), for each year that an individual is enrolled in the premium assistance program, the Secretary shall provide premium assistance to such individual in an amount determined by the Secretary that is based on the geographic location of the individual and the cost of applicable health insurance coverage and benefits in such area.

''(B) COMPUTATION OF PREMIUM ASSISTANCE AMOUNTS.—The amount of premium assistance provided to an individual located in a geographic area for a year shall be computed at 120 percent of the sum of the median premium and median deductible payment for such year for all health insurance coverage offered by health insurance issuers in the individual market serving such area.

''(4) PERMISSIBLE USE OF PREMIUM ASSISTANCE.—Premium assistance under paragraph (3) may be used only for the following purposes:

''(A) For payment of premiums, deductibles, copayments, or other cost-sharing for enrollment of such individual for health insurance coverage offered by health insurance issuers in the individual market.

''(B) As a contribution into a MSA plan established by such individual, as defined in section 138(b)(2) of the Internal Revenue Code of 1986.

''(5) MSA DEPOSITS.—The amount of the premium assistance received by an individual under this subsection shall be deposited, on behalf of such individual, into the MSA plan of such individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the first January 1 after the date of the enactment of this Act.

TITLE IV—EMTALA REFORMS

SEC. 401. EMTALA REFORMS.

(a) USE OF QUALIFIED EMERGENCY DEPARTMENT PERSONNEL IN PERFORMING INITIAL SCREENING.—Subsection (a) of section 1867 of the Social Security Act (42 U.S.C. 1395dd) is amended—

(1) by designating the sentence beginning with ''In the case of'' as paragraph (1), with the heading ''IN GENERAL.—'' and appropriate indentation; and

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

''(2) PERMITTING APPLICATION OF ER TRIAGE.—

''(A) IN GENERAL.—The requirement of paragraph (1) that a hospital conduct an appropriate medical screening examination of an individual is deemed to be satisfied if a qualified emergency screener (as defined in subparagraph (B)) performs a preliminary triage-type screening in which the personnel—

''(i) assesses the nature and extent of the individual's illness or injury; and

''(ii) determines, based on such assessment, that an emergency medical condition does not exist.

''(B) QUALIFIED EMERGENCY SCREENER DEFINED.—In this paragraph, the term 'qualified emergency screener' means a physician, licensed practical nurse or registered nurse, qualified emergency medical technician, or other individual with basic, health care education that meets standards specified by the Secretary as being sufficient to perform the screening described in subparagraph (A).''.

(b) REVISION OF EMERGENCY MEDICAL CONDITION DEFINITION.—Subsection (e)(1)(A) of such section is amended to read as follows:

''(A) a medical condition manifesting itself by symptoms of sufficient severity (including severe pain) and with an onset or of a course such that the absence of immediate medical attention could reasonably be expected to pose an immediate risk to life or long-term health of the individual (or, with respect to a pregnant woman, the life or long-term health of the woman or her unborn child); or''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to individuals who come to an emergency room on or after the date that is 30 days after the date of the enactment of this Act.

TITLE V—COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE

SEC. 501. COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.

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

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual or group 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 or group health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

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

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

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) GROUP HEALTH INSURANCE COVERAGE.—The term 'group health insurance coverage' has the meaning given such term in 2791(b)(4).

''(6) 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.

''(7) 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.

''(8) COVERED LAWS.—

"(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

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

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

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

"(iv) the provision to an individual in relation to individual or group 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 or group 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.

''(9) 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.

''(10) 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 materi-

ally altered without notice to, or knowledge or consent of, the insured.

''(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

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

''(11) 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 busi-

ness of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

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

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

''SEC. 2796. APPLICATION OF LAW.

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

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual or group health insurance coverage

in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

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

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

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

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

''(i) the State insurance commissioner of the primary State has not done an 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 as-

sociation 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 or group health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

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

"(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice,

in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned: 'Notice: This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'

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

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual or group 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 or group 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 or group health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual or group 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 or group health insurance coverage in such State—

''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

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

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

''(2) to the insurance commissioner of each secondary State in which it offers individual or group health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

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

''(B) a qualified loss reserve specialist.

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

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

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

''(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be

construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

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

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

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

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

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

''(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a

health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering 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 or group 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 or group health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual or group

health insurance coverage in a secondary State under the provisions of this title unless—

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

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

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

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

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

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

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

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

''(A) is appropriately credentialed or licensed in 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 osteo-

pathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

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

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to

individual patients on average at least 2 days per week.

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

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

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

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

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

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

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

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

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

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

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

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

''(A) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''SEC. 2799. ENFORCEMENT.

''(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual or group 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, or group health insurance coveraged offered by a health insurance issuer 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 health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

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