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112TH CONGRESS
2D SESSION

H. R. 4242

To repeal the Patient Protection and Affordable Care Act, to amend the Public Health Service Act to provide individual and group market reforms to protect health insurance consumers, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 22, 2012

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

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A BILL

To repeal the Patient Protection and Affordable Care Act, to amend the Public Health Service Act to provide individual and group market reforms to protect health insurance consumers, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Ensuring Quality Health Care for All Americans Act of 2012''.

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

SEC. 2. REPEAL OF PPACA.

(a) PPACA.—Public Law 111–148 is repealed, and the provisions of law amended or repealed by such Act are restored or revived as if such Act had not been enacted.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) HCERA.—Title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152) are repealed, and the provisions of law amended or repealed by such title or subtitle, respectively, are restored or revived as if such title and subtitle had not been enacted.

SEC. 3. PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS.

(a) GROUP MARKET.—Subpart 3 of part A of title XXVII of the Public Health Service Act is amended by striking section 2711 and inserting the following:

"SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE.

''(a) GUARANTEED ISSUANCE OF COVERAGE IN THE GROUP MARKET.—

''(1) IN GENERAL.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the group market in a State shall accept every employer and every individual in a group in the State that applies for such coverage.

''(2) SPECIAL RULE FOR ASSOCIATIONS.—An association shall be treated as an employer for purposes of this section if such association seeks to provide group health insurance coverage to not less than 200 qualified individuals.

''(b) ENROLLMENT.—

''(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

''(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (as such term is defined in section 603 of the Employee Retirement Income Security Act of 1974).

''(3) SPECIAL RULES FOR ASSOCIATIONS.—

''(A) QUALIFYING EVENTS.—For purposes of applying paragraph (2) to an association—

''(i) the term 'covered employee' in section 603 of the Employee Retirement Income Security Act of 1974 shall include a qualified individual (as such term is defined in section 2701(d)(2)(D));

''(ii) the term 'employer' shall include an association (as such term is defined in section 2701(d)(2)(A)); and

''(iii) the term 'termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment' shall include the termination of membership to the association.

''(B) ENROLLMENT.—With respect to health insurance coverage provided to an association under subsection (a)(2), a health insurance issuer shall permit a qualified individual who is eligible, but not enrolled (or a dependent of such individual if the dependent is eligible, but not enrolled) for such coverage to enroll for

coverage under the terms of such coverage when any one of the following events occur:

"(i) NEW MEMBERS AND EMPLOYEES.—A qualified individual, and any dependent of such individual, may enroll during the 30-day period following the end of the period described under section 2701(d)(2)(D) that applies to such individual.

"(ii) ANNUAL ENROLLMENT.—A qualified individual, and any dependent of such individual, may enroll during the annual enrollment period established under the terms of the coverage

"(C) TERMINATION OF ENROLLMENT.—With respect to group health insurance coverage provided by an association, a qualified individual or dependent who terminates enrollment in such coverage may only re-enroll in such coverage during the annual enrollment period described under subparagraph (B)(ii).

"(D) DEFINITIONS.—For purposes of this section, the terms 'association' and 'qualified individual' have the meaning given such terms in section 2701(d)(2).

''(4) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under this subsection.

''(c) SPECIAL RULES FOR NETWORK PLANS.—

''(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the group market in a State through a network plan, the issuer may—

''(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

''(B) within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated, if required, to the applicable State authority that—

''(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

''(ii) it is applying this paragraph uniformly to all employers without regard to—

"(I) the claims experience of those employers and their employees (and their dependents); or

"(II) any health-status-related factor relating to such employees and dependents.

"(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group market within such service area for a period of 180 days after the date such coverage is denied.

"(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

"(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the group if the issuer has demonstrated, if required, to the applicable State authority that—

"(A) it does not have the financial reserves necessary to underwrite additional coverage; and

"(B) it is applying this paragraph uniformly to all employers and individuals in the group market in the State—

"(i) in a manner that is consistent with applicable State law; and

"(ii) without regard to—

"(I) the claims experience of those individuals, employers, and their employees (and their dependents); or

"(II) any health-status-related factor relating to such individuals, employees, and dependents.

"(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.".

(b) INDIVIDUAL MARKET.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by striking section 2741 and inserting the following:

"SEC. 2741. GUARANTEED AVAILABILITY OF COVERAGE.

"The provisions of section 2711 (other than subsection (a)(2) and subsection (b)(3)) shall apply to health insurance coverage offered to individuals by a health insurance issuer in the individual market in the same manner as such provisions apply to health insurance coverage offered to employers by a health insurance issuer in connection with health insurance coverage in the group market. For purposes of this section, the Secretary shall treat any reference of the word 'employer' in such section as a reference to the term 'individual'.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective for plan years beginning on or after January 1, 2014.

SEC. 4. GUARANTEED RENEWABILITY OF COVERAGE.

(a) GROUP MARKET.—Section 2712 of the Public Health Service Act is amended—

(1) in subsection (a)—

(A) by inserting ", including coverage offered" before "in connection with a group health plan"; and

(B) by inserting ''employer or other'' before ''plan sponsor of the plan'';

(2) in subsection (b)—

(A) in the matter before paragraph (1), by striking ''health insurance coverage in connection with a group health plan in the small or large group market'' and insert ''such health insurance coverage''; and

(B) in paragraph (6) by striking '' one or more bona fide associations'' and inserting ''one or more associations (as such term is defined in section 2701(d)(2)(A))'';

(3) in subsection (c)(1)(B), by striking ''to a group health plan'';

(4) in subsection (d)—

(A) in matter before paragraph (1), by striking ''to a group health plan''; and

(B) in paragraph (2), by striking ''bona fide associations'' and inserting ''associations (as such term is defined in section 2701(d)(2)(A))''; and

(5) in subsection (e), by inserting ''(as such term is defined in section 2701(d)(2)(A))'' after ''one or more associations''.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective for plan years beginning on or after January 1, 2014.

SEC. 5. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS AND OTHER DISCRIMINATION BASED ON HEALTH STATUS.

(a) GROUP MARKET.—Subpart 1 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg) is amended by striking section 2701 and inserting the following:

"SEC. 2701. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS AND OTHER DISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

''(b) DEFINITIONS.—For purposes of this part:

''(1) PREEXISTING CONDITION EXCLUSION.—

''(A) IN GENERAL.—The term 'preexisting condition exclusion' means, with respect to a group health plan or health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment in

such plan or for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

''(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

''(2) DATE OF ENROLLMENT.—The term 'date of enrollment' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

''(3) WAITING PERIOD.—The term 'waiting period' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

''(c) SPECIAL ENROLLMENT PERIODS.—

''(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer

offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

''(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

''(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

''(C) The employee's or dependent's coverage described in subparagraph (A)—

"(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

"(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

"(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

"(2) FOR DEPENDENT BENEFICIARIES.—

"(A) IN GENERAL.—If—

"(i) a group health plan makes coverage available with respect to a dependent of an individual;

"(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant

under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and

''(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

''(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

''(i) the date dependent coverage is made available; or

''(ii) the date of the marriage, birth, or adoption or placement for adoption (as

the case may be) described in subparagraph (A)(iii).

''(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

''(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

''(ii) in the case of a dependent's birth, as of the date of such birth; or

''(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

''(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

''(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of

such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan or coverage if either of the following conditions is met:

"(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

"(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including

under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

''(B) COORDINATION WITH MEDICAID AND CHIP.—

''(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

''(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee

of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

''(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent

with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

"(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID- AND CHIP- ELIGIBLE INDIVIDUALS.—In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to establish (under paragraph

(2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) the cost effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

''(d) APPLICATION TO ASSOCIATION PLANS.—

''(1) IN GENERAL.—A group health plan or health insurance issuer that provides coverage to an association as required under section 2711(a)(2) shall accept every qualified individual that the association seeks health insurance coverage for, without regard to the health status of such individual.

''(2) DEFINITIONS RELATED TO ASSOCIATIONS.—For purposes of this subsection:

''(A) ASSOCIATION.—The term 'association' means an association that—

''(i) has a constitution and bylaws;

''(ii) is determined by the Secretary to be an association which is operating in good faith for a primary purpose other than that of obtaining insurance; and

''(iii) has been in existence for a period of at least 5 years.

''(B) DEPENDENT.—The term 'dependent', with respect to a qualified individual, has the meaning given such term in section 2714, with respect to a policy holder.

''(C) QUALIFIED ACTUARY.—The term 'qualified actuary' means a member in good standing of the American Academy of Actuaries, or a successor organization approved by the Secretary.

''(D) QUALIFIED INDIVIDUALS.—The term 'qualified individual' means, with respect to an association, an individual who meets any of the following:

''(i) A member of the association who has been such a member for a period of at least 30 days.

''(ii) An employee of such member who has been employed by such member for a period of at least 30 days.

''(iii) An employee of the association who has been employed by the association for a period of at least 30 days.''.

(b) INDIVIDUAL MARKET.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2746. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

''The provisions of section 2701 (other than subparagraphs (A)(ii) and (B) of subsection (c)(3)) shall apply to health insurance coverage offered to individuals by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in the group market.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective for plan years beginning on or after January 1, 2014, except, to the extent such amendments apply to enrollees who are under 19 years of age, such amendments shall become effective for plan years beginning on or after 6 months after the date of enactment of this Act.

SEC. 6. NO LIFETIME OR ANNUAL LIMITS.

(a) GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2708. NO LIFETIME OR ANNUAL LIMITS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group health insurance coverage may not establish—

''(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

''(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

''(b) PER BENEFICIARY LIMITS.—A group health plan or health insurance coverage may not place annual or lifetime per beneficiary limits on specific covered benefits unless such limits are otherwise permitted under Federal or State law.''.

(b) INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2754. NO LIFETIME OR ANNUAL LIMITS.

''The provisions of section 2708 shall apply to health insurance coverage offered to individuals by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in the group market.''.

(c) EFFECTIVE DATE.—The amendment made by this section shall be effective for plan years beginning on or after 6 months after the date of enactment of this Act.

SEC. 7. PROHIBITION ON RESCISSIONS.

(a) GROUP MARKET.—Subpart 1 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2703. PROHIBITION ON RESCISSIONS.

''A group health plan and a health insurance issuer offering group health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2712(b).''.

(b) INDIVIDUAL MARKET.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2747. PROHIBITION ON RESCISSIONS.

''The provisions of section 2703 shall apply to health insurance coverage offered to individuals by a health in-

surance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in the group market.''.

(c) EFFECTIVE DATE.—The amendment made by this section shall be effective for plan years beginning on or after 6 months after the date of enactment of this Act.

SEC. 8. EXTENSION OF DEPENDENT COVERAGE.

(a) GROUP MARKET.—

(1) IN GENERAL.—Subpart 1 of part A of title XXVII of the Public Health Service Act is amended by adding at the end:

''SEC. 2703A. EXTENSION OF DEPENDENT COVERAGE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for such a dependent after such dependent turns 18 years of age until the first of the following events occurs:

''(1) The dependent turns 26 years of age.

''(2) The dependent marries.

''(3) Subject to subsection (c), the dependent no longer resides in the home of—

''(A) the policy holder through which such dependent is eligible for dependent coverage; or

''(B) in the case that the policy holder through which such dependent is eligible for dependent coverage provides such coverage subject to an order to provide child support, the dependent's parent or legal guardian.

''(b) EXCEPTION FOR COLLEGE STUDENTS.—Paragraph (3) of subsection (a) shall not apply to a dependent for any period of time during which such dependent is enrolled as a full-time student at a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965).

''(c) LIMITATION.—Nothing in this section shall require a plan or an issuer described in subsection (a) to make coverage available for a child of an individual receiving dependent coverage pursuant to this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the definition of 'dependent' as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.''.

(2) REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary shall promulgate regulations to define the dependents to which coverage shall be made available

under section 2703A of the Public Health Service Act, as added by paragraph (1).

(b) INDIVIDUAL MARKET.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2748. EXTENSION OF DEPENDENT COVERAGE.

''The provisions of section 2703A shall apply to health insurance coverage offered to individuals by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in the group market.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective for plan years beginning on or after 6 months after the date of enactment of this Act.

SEC. 9. APPLICATION OF GROUP MARKET REFORMS TO ERISA AND THE INTERNAL REVENUE CODE OF 1986.

(a) ERISA.—

(1) IN GENERAL.—Subpart A of title VII of the Employee Retirement Income Security Act of 1974 is amended—

(A) by striking sections 701 and 703; and

(B) by inserting before section 702 the following:

"SEC. 701. APPLICATION OF CERTAIN PHSA REQUIREMENTS.

"(a) IN GENERAL.—Sections 2701, 2703, 2703A, 2708, 2711, and 2712 of the Public Health Service Act shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart.

"(b) CONFLICT.—To the extent that any provision of this part conflicts with a provision of any section of the Public Health Service Act listed in subsection (a) with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such sections shall apply.".

(2) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended—

(A) by striking the item related to section 701 and inserting "Sec. 701. Application of certain PHSA requirements."; and

(B) by striking the item related to section 703.

(b) INTERNAL REVENUE CODE OF 1986.—Subchapter A of chapter 100 of the Internal Revenue Code of 1986 (relating to group health plan requirements) is amended—

(1) by striking sections 9801 and 9803; and

(2) by inserting before section 9802 the following:

"SEC. 9801. APPLICATION OF CERTAIN PHSA REQUIREMENTS.

"(a) IN GENERAL.—Sections 2701, 2703, 2703A, 2708, 2711, and 2712 of the Public Health Service Act shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter.

"(b) CONFLICT.—To the extent that any provision of this subchapter conflicts with a provision of any section of the Public Health Service Act listed in subsection (a) with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such sections shall apply.".

SEC. 10. CATASTROPHIC PLAN.

(a) IN GENERAL.—Subpart 1 of part B of title XXVII of the Public Health Service Act is amended by adding at the end the following:

"SEC. 2749. CATASTROPHIC PLAN.

"(a) IN GENERAL.—Each health insurance issuer that offers health insurance coverage in the individual market in a State shall offer a catastrophic plan in such State in such market.

''(b) COVERAGE REQUIREMENTS.—To meet the requirements of this section, a catastrophic plan must provide for the essential health benefits, as defined by the Secretary under subsection (c).

''(c) ESSENTIAL HEALTH BENEFITS.—The Secretary shall define the essential health benefits, except that such benefits shall include—

''(1) coverage for at least three primary care visits during a plan year; and

''(2) at least the following general categories and the items and services covered within the categories:

''(A) Ambulatory patient services.

''(B) Emergency services.

''(C) Hospitalization.

''(D) Maternity and newborn care.

''(E) Mental health and substance use disorder services, including behavioral health treatment.

''(F) Prescription drugs.

''(G) Rehabilitative and habilitative services and devices.

''(H) Laboratory services.

''(I) Preventive and wellness services and chronic disease management.

''(J) Pediatric services, including oral and vision care.

''(d) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this section, the issuer may only offer the plan in the individual market.''.

(b) EFFECTIVE DATE.—This section shall be effective for plan years beginning on or after 6 months after the date of enactment of this Act.

SEC. 11. GRANTS FOR HEALTH INSURANCE RISK ADJUSTMENT MECHANISMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall make grants to States for planning for the establishment and implementation of health insurance risk adjustment mechanisms.

(b) AMOUNT.—

(1) IN GENERAL.—The Secretary shall determine the amount of a grant made to a State under this section pursuant to a formula, issued by rule not later than January 1, 2013, that takes into account the number of high-risk individuals in such State.

(2) LIMITATION.—The amount of a grant made to a State under this section shall not exceed $1,000,000 for any fiscal year.

(c) USE OF FUNDS.—The grant funds made available to a State under this section may only be used by a State for the cost associated with planning for the establishment and implementation of health insurance risk adjustment mechanisms. Such funds may not be used for costs related to administering such mechanisms.

(d) DEFINITIONS.—For purposes of this section:

(1) HIGH-RISK INDIVIDUAL.—The term ''high-risk individual'' means an individual who—

(A) is a citizen or national of the United States or is lawfully present in the United States;

(B) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on March 22, 2010) during the previous 6-month period; and

(C) has a preexisting condition, as determined in a manner consistent with guidance issued by the Secretary.

(2) HEALTH INSURANCE RISK-ADJUSTMENT MECHANISMS.—

(A) IN GENERAL.—With respect to a State, the term ''health insurance risk-adjust-

ment mechanism'' shall be a mechanism that applies to—

(i) all health insurance issuers who offer health insurance coverage in such State; and

(ii) all covered lives for health insurance coverage offered in such State that is subject to the requirements of section 2711 or section 2741 of the Public Health Service Act, as added by section 3 of this Act.

(B) FURTHER DEFINITION.—With respect to a State, any further definition of such term shall be determined by the State insurance commissioner, acting in cooperation with health insurance issuers who offer health insurance coverage in such State.

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

(e) SUNSET DATE.—The Secretary may not make any grants under this section after December 31, 2014.

SEC. 12. LIABILITY PROTECTIONS FOR HEALTH CARE PROVIDERS.

(a) HEALTH CARE PROVIDERS PROTECTED.—The liability protections in subsection (c) shall apply in any civil action, including an action before any court of any State,

against a health care provider, arising from health care goods or services that—

(1) were provided by a health care provider in a hospital to which the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) apply; and

(2) were provided only because they were required under section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) BURDEN OF PROOF.—In any proceeding under subsection (a), the burden of proof shall be on the defendant to establish the elements in paragraphs (1) and (2) of subsection (a).

(c) LIABILITY PROTECTIONS.—

(1) CAP ON NONECONOMIC DAMAGES.—The amount of noneconomic damages, if available, shall not exceed $250,000, regardless of the number of parties against whom the action is brought with respect to the same injury. An award for noneconomic damages in excess of $250,000 shall be reduced either before entry of the order granting judgment, or by amendment of such order.

(2) INSTALLMENT PAYMENTS.—If the award for damages exceeds $50,000, the defendant may

pay such damages in installments, as determined by the court.

(3) ATTORNEY FEES.—Any contingent fee for a party's attorney shall not exceed—

(A) 40 percent of the portion of the award amount that does not exceed $50,000;

(B) 33⅓ percent of the portion of the award amount that exceeds $50,000 but does not exceed $100,000;

(C) 25 percent of the portion of the award amount that exceeds $100,000 but does not exceed $600,000; and

(D) 15 percent of the portion of the award amount that exceeds $600,000.

(4) DISCLOSURE OF COLLATERAL SOURCE BENEFITS.—Any person bringing a civil action described in subsection (a) shall, and any party may, disclose or introduce evidence of collateral source benefits.

(5) PREEMPTION.—

(A) IN GENERAL.—The provisions of this Act preempt, subject to subparagraphs (B) and (C), State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing an action described in subsection (a)

set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(i) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or

(ii) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(B) GREATER PROTECTIONS PRESERVED.—This Act shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers from liability, loss, or damages than those provided by this Act or create a cause of action.

(C) RULE OF CONSTRUCTION.—No provision of this Act shall be construed to preempt—

(i) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a par-

ticular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in an action described in subsection (a), regardless of whether such monetary amount is greater or lesser than is provided for under this Act; or

(ii) any defense available to a party in an action described in subsection (a) under any other provision of State or Federal law.

(6) DEFINITIONS.—

(A) COLLATERAL SOURCE BENEFITS.—As used in this section, the term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the personal harm, pursuant to—

(i) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(ii) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(iii) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(iv) any other publicly or privately funded program.

(B) NONECONOMIC DAMAGES.—As used in this section, the term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(C) HEALTH CARE PROVIDER.—As used in this section, the term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, reg-

istered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute.

(D) HEALTH CARE GOODS OR SERVICES.—As used in this section, the term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

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