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(Original Signature of Member)

112TH CONGRESS  
2D SESSION

# H. R.

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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.

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## IN THE HOUSE OF REPRESENTATIVES

Mr. BROUN of Georgia introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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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.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; CON-**  
4 **STRUCTION.**

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

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

Sec. 1. Short title; table of contents; construction.

TITLE I—REPEAL OF PPACA AND HCERA

Sec. 101. Repeal of PPACA and HCERA.

TITLE II—HEALTH CARE TAX REFORM

Subtitle A—HSA Reform

Sec. 201. Repeal of high deductible health plan requirement.

Sec. 202. Increase in deductible HSA contribution limitations.

Sec. 203. Medicare eligible individuals eligible to contribute to HSA.

Sec. 204. HSA Rollover to Medicare Advantage MSA.

Sec. 205. Repeal of additional tax on distributions not used for qualified medical expenses.

Subtitle B—Other Health Care Tax Reform

Sec. 206. Elimination of 7.5-percent floor on medical expense deductions.

Sec. 207. Repeal of prescribed drug limitation on certain tax benefits for medical expenses.

Sec. 208. Repeal of 2-percent miscellaneous itemized deduction floor for medical expense deductions.

Sec. 209. Charity care credit.

Sec. 210. COBRA continuation coverage extended.

Sec. 211. HSA charitable contributions.

TITLE III—MEDICARE PREMIUM ASSISTANCE PROGRAM

Sec. 301. Replacement of Medicare part A entitlement with Medicare Reform Premium Assistance Program.

TITLE IV—EMTALA REFORMS

Sec. 401. EMTALA reforms.

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

Sec. 501. Cooperative governing of individual and group health insurance coverage.

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

5 **TITLE I—REPEAL OF PPACA AND**  
6 **HCERA**

7 **SEC. 101. REPEAL OF PPACA AND HCERA.**

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

14 **TITLE II—HEALTH CARE TAX**  
15 **REFORM**

16 **Subtitle A—HSA Reform**

17 **SEC. 201. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN RE-**  
18 **QUIREMENT.**

19 (a) IN GENERAL.—Section 223 of the Internal Rev-  
20 enue Code of 1986 is amended by striking subsection (c)  
21 and redesignating subsections (d) through (h) as sub-  
22 sections (c) through (g), respectively.

1 (b) CONFORMING AMENDMENTS.—

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

4 “(a) DEDUCTION ALLOWED.—In the case of an indi-  
5 vidual, there shall be allowed as a deduction for a taxable  
6 year an amount equal to the aggregate amount paid in  
7 cash during such taxable year by or on behalf of such indi-  
8 vidual to a health savings account of such individual.”.

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

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

14 (A) by striking “subsection (f)(5)” and in-  
15 serting “subsection (e)(5)”, and

16 (B) in clause (ii)—

17 (i) by striking “the sum of—” and all  
18 that follows and inserting “the dollar  
19 amount in effect under subsection (b)(1).”.

20 (4) Section 223(f)(1) of such Code (as redesi-  
21 gnated by subsection (b)(1)) is amended by striking  
22 “Each dollar amount in subsections (b)(2) and  
23 (c)(2)(A)” and inserting “In the case of a taxable  
24 year beginning after December 31, 2010, each dollar  
25 amount in subsection (b)(1)”.

1           (5) Section 26(b)(U) of such Code is amended  
2           by striking “section 223(f)(4)” and inserting “sec-  
3           tion 223(e)(4)”.

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

8           (7) Section 106(d)(1) of such Code is amend-  
9           ed—

10           (A) by striking “who is an eligible indi-  
11           vidual (as defined in section 223(c)(1))”, and

12           (B) by striking “section 223(d)” and in-  
13           serting “section 223(c)”.

14           (8) Section 408(d)(9) of such Code is amend-  
15           ed—

16           (A) in subparagraph (A) by striking “who  
17           is an eligible individual (as defined in section  
18           223(c)) and”, and

19           (B) in subparagraph (C) by striking “com-  
20           puted on the basis of the type of coverage under  
21           the high deductible health plan covering the in-  
22           dividual at the time of the qualified HSA fund-  
23           ing distribution”.

1           (9) Section 877A(g)(6) of such Code is amend-  
2       ed by striking “223(f)(4)” and inserting  
3       “223(e)(4)”.

4           (10) Section 4973(g) of such Code is amend-  
5       ed—

6           (A) by striking “section 223(d)” and in-  
7       serting “section 223(c)”,

8           (B) in paragraph (2), by striking “section  
9       223(f)(2)” and inserting “section 223(e)(2)”,  
10       and

11          (C) by striking “section 223(f)(3)” and in-  
12       serting “section 223(e)(3)”.

13          (11) Section 4975 of such Code is amended—

14          (A) in subsection (c)(6)—

15               (i) by striking “section 223(d)” and  
16       inserting “section 223(c)”, and

17               (ii) by striking “section 223(e)(2)”  
18       and inserting “section 223(d)(2)”, and

19          (B) in subsection (e)(1)(E), by striking  
20       “section 223(d)” and inserting “section  
21       223(c)”.

22          (12) Section 6693(a)(2)(C) of such Code is  
23       amended by striking “section 223(h)” and inserting  
24       “section 223(g)”.

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

4 **SEC. 202. INCREASE IN DEDUCTIBLE HSA CONTRIBUTION**  
5 **LIMITATIONS.**

6 (a) IN GENERAL.—Paragraph (1) of section 223(b)  
7 of the Internal Revenue Code of 1986 is amended by strik-  
8 ing “the sum of the monthly” and all that follows through  
9 “eligible individual” and inserting “\$10,000 (\$20,000 in  
10 the case of a joint return)”.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Subsection (b) of such Code is amended by  
13 striking paragraphs (2), (3), and (5) and by redesignig-  
14 nating paragraphs (4), (6), and (7) as paragraphs  
15 (2), (3), and (4), respectively.

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

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

22 **SEC. 203. MEDICARE ELIGIBLE INDIVIDUALS ELIGIBLE TO**  
23 **CONTRIBUTE TO HSA.**

24 (a) Subsection (b) of section 223 of the Internal Rev-  
25 enue Code of 1986 is amended by striking paragraph (7).

1 (b) Paragraph (1) of section 223(c) of such Code is  
2 amended by adding at the end the following new subpara-  
3 graph:

4 “(C) SPECIAL RULE FOR INDIVIDUALS EN-  
5 TITLED TO BENEFITS UNDER MEDICARE.—In  
6 the case of an individual—

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

9 “(ii) with respect to whom a health  
10 savings account is established in a month  
11 before the first month such individual is  
12 entitled to such benefits,

13 such individual shall be deemed to be an eligible  
14 individual.”.

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

18 **SEC. 204. HSA ROLLOVER TO MEDICARE ADVANTAGE MSA.**

19 (a) IN GENERAL.—Paragraph (2) of section 138(b)  
20 of the Internal Revenue Code of 1986 is amended by strik-  
21 ing “or” at the end of subparagraph (A), by adding “or”  
22 at the end of subparagraph (C), and by adding at the end  
23 the following new subparagraph:

24 “(C) a HSA rollover contribution described  
25 in subsection (d)(5),”.

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

4 “(5) ROLLOVER CONTRIBUTION.—An amount is  
5 described in this paragraph as a rollover contribu-  
6 tion if it meets the requirement of subparagraphs  
7 (A) and (B).

8 “(A) IN GENERAL.—The requirements of  
9 this subparagraph are met in the case of an  
10 amount paid or distributed from a health sav-  
11 ings to the account beneficiary to the extent the  
12 amount is received is paid into a Medicare Ad-  
13 vantage MSA of such beneficiary not later than  
14 the 60th day after the day on which the bene-  
15 ficiary receives the payment or distribution.

16 “(B) LIMITATION.—This paragraph shall  
17 not apply to any amount described in subpara-  
18 graph (A) received by an individual from a  
19 health savings account if, at any time during  
20 the 1-year period ending on the day of such re-  
21 ceipt, such individual received any other amount  
22 described in subparagraph (A) from a health  
23 savings account which was not includible in the  
24 individual’s gross income because of the appli-  
25 cation of section 223(f)(5)(A).”.

1 (c) CONFORMING AMENDMENT.—Subparagraph (A)  
2 of section 223(f)(5) of such Code is amended by inserting  
3 “or Medicare Advantage MSA” after “into a health sav-  
4 ings account”.

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

8 **SEC. 205. REPEAL OF ADDITIONAL TAX ON DISTRIBUTIONS**  
9 **NOT USED FOR QUALIFIED MEDICAL EX-**  
10 **PENSES.**

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

15 (b) CONFORMING AMENDMENTS.—

16 (1) Paragraph (2) of section 25(b) of such Code  
17 is amended by striking subparagraph (U) and by re-  
18 designating subparagraphs (V), (W), and (X) as  
19 subparagraphs (U), (V), and (W).

20 (2) Subparagraph (C) of section 106(e)(4) of  
21 such Code is amended by striking “223(f)(5)” and  
22 inserting “223(f)(4)”.

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



1           (1) IN GENERAL.—Section 213 of the Internal  
2 Revenue Code of 1986 is amended by striking sub-  
3 section (b).

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

7           (b) TREATMENT OF REIMBURSEMENTS UNDER ACCI-  
8 DENT OR HEALTH PLANS.—Section 106 of such Code is  
9 amended by striking subsection (f).

10          (c) HEALTH SAVINGS ACCOUNTS.—Subparagraph  
11 (A) of section 223(d)(2) of such Code is amended by strik-  
12 ing the last sentence thereof.

13          (d) ARCHER MSAS.—Subparagraph (A) of section  
14 220(d)(2) of such Code is amended by striking the last  
15 sentence thereof.

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

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

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

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

4 **SEC. 209. CHARITY CARE CREDIT.**

5 (a) IN GENERAL.—Subpart A of part IV of sub-  
 6 chapter A of chapter 1 of the Internal Revenue Code of  
 7 1986 (relating to nonrefundable personal credits) is  
 8 amended by inserting after section 25D the following new  
 9 section:

10 **“SEC. 25E. CHARITY CARE CREDIT.**

11 “(a) ALLOWANCE OF CREDIT.—In the case of a phy-  
 12 sician, there shall be allowed as a credit against the tax  
 13 imposed by this chapter for a taxable year the amount  
 14 determined in accordance with the following table:

<b>“If the physician has provided during such taxable year:</b>	<b>The amount of the credit is:</b>
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.

1       “(b) QUALIFIED HOURS OF CHARITY CARE.—For  
2 purposes of this section—

3               “(1) QUALIFIED HOURS OF CHARITY CARE.—

4       The term ‘qualified hours of charity care’ means the  
5 hours that a physician provides medical care (as de-  
6 fined in section 213(d)(1)(A)) on a volunteer or pro  
7 bono basis.

8               “(2) PHYSICIAN.—The term ‘physician’ has the  
9 meaning given to such term in section 1861(r) of the  
10 Social Security Act (42 U.S.C. 1395x(r)).”.

11       (b) CONFORMING AMENDMENT.—The table of sec-  
12 tions for subpart A of part IV of subchapter A of chapter  
13 1 of such Code is amended by inserting after the item  
14 relating to section 25D the following new item:

“Sec. 25E. Charity care credit.”.

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

18 **SEC. 210. COBRA CONTINUATION COVERAGE EXTENDED.**

19       (a) UNDER IRC.—Subparagraph (B) of section  
20 4980B(f)(2) of the Internal Revenue Code of 1986 is

1 amended by striking clauses (i) and (v) and by redesignig-  
2 nating clauses (ii), (iii), and (iv) as clauses (i), (ii), and  
3 (iii), respectively.

4 (b) UNDER ERISA.—Paragraph (2) of section 602  
5 of the Employee Retirement Income Security Act of 2009  
6 (29 U.S.C. 1162) is amended by striking subparagraphs  
7 (A) and (E) and by redesignating subparagraphs (B), (C),  
8 and (D) as subparagraphs (A), (B), and (C), respectively.

9 (c) UNDER PHSA.—Paragraph (2) of section  
10 2202(2) of the Public Health Service Act (42 U.S.C.  
11 300bb–2(2)) is amended by striking subparagraphs (A)  
12 and (E) and by redesignating subparagraphs (B), (C), and  
13 (D) as subparagraphs (A), (B), and (C), respectively.

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

19 **SEC. 211. HSA CHARITABLE CONTRIBUTIONS.**

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

23 “(9) DISTRIBUTIONS FOR CHARITABLE PUR-  
24 POSES.—For purposes of this subsection—

1           “(A) IN GENERAL.—Paragraph (2) shall  
2 not apply to any qualified charitable distribu-  
3 tions with respect to a taxpayer made during  
4 any taxable year.

5           “(B) QUALIFIED CHARITABLE DISTRIBUTION.—For purposes of this paragraph, the  
6 term ‘qualified charitable distribution’ means  
7 any distribution from a health savings account  
8 which is made directly by the trustee to an or-  
9 ganization described in section 170(b)(1)(A)  
10 (other than any organization described in sec-  
11 tion 509(a)(3) or any fund or account described  
12 in section 4966(d)(2)). A distribution shall be  
13 treated as a qualified charitable distribution  
14 only to the extent that the distribution would be  
15 includible in gross income without regard to  
16 subparagraph (A).  
17

18           “(C) CONTRIBUTIONS MUST BE OTHER-  
19 WISE DEDUCTIBLE.—For purposes of this para-  
20 graph, a distribution to an organization de-  
21 scribed in subparagraph (B) shall be treated as  
22 a qualified charitable distribution only if a de-  
23 duction for the entire distribution would be al-  
24 lowable under section 170 (determined without

1 regard to subsection (b) thereof and this para-  
2 graph).

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

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

## 11 **TITLE III—MEDICARE PREMIUM** 12 **ASSISTANCE PROGRAM**

### 13 **SEC. 301. REPLACEMENT OF MEDICARE PART A ENTITLE-** 14 **MENT WITH MEDICARE REFORM PREMIUM** 15 **ASSISTANCE PROGRAM.**

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

19 “(k) REPLACEMENT OF ENTITLEMENT WITH PRE-  
20 MIUM ASSISTANCE PROGRAM.—

21 “(1) IN GENERAL.—Notwithstanding the pre-  
22 vious provisions of this section, beginning the first  
23 January 1 after the date of the enactment of the Of-  
24 fering Patients True Individualized Options Act of

1       2011, the Secretary shall establish procedures under  
2       which—

3               “(A) in the case of an individual who, but  
4               for the application of this paragraph, would  
5               otherwise become entitled under subsection (a)  
6               on or after such January 1 to benefits under  
7               part A of title XVIII, subject to paragraph (4),  
8               the individual shall in lieu of such entitlement  
9               be automatically enrolled in the Medicare Re-  
10              form Premium Assistance Program established  
11              under subsection (l); and

12             “(B) in the case of an individual who be-  
13             fore such January 1 is entitled under sub-  
14             section (a) to benefits under part A of title  
15             XVIII, the individual may in lieu of such enti-  
16             tlement elect on or after such January 1 to en-  
17             roll in the Medicare Reform Premium Assist-  
18             ance Program established under subsection (l).

19             “(2) TREATMENT UNDER THE INTERNAL REV-  
20             ENUE CODE OF 1986.—An individual who is enrolled  
21             under the Medicare Reform Premium Assistance  
22             Program under paragraph (1) shall not be treated  
23             as entitled to benefits under title XVIII for purposes  
24             of section 223(b)(7) of the Internal Revenue Code of  
25             1986.

1           “(3) INELIGIBILITY FOR PART B OR D BENE-  
2           FITS.—An individual shall not be eligible for benefits  
3           under part B or D of title XVIII once the individual  
4           is enrolled in the Medicare Reform Premium Assist-  
5           ance Program under paragraph (1).

6           “(4) OPT OUT.—

7                   “(A) IN GENERAL.—Any individual who is  
8                   otherwise eligible for automatic enrollment in  
9                   the Medicare Reform Premium Assistance Pro-  
10                  gram under paragraph (1)(A) may elect (in  
11                  such form and manner as may be specified by  
12                  the Secretary of Health and Human Services)  
13                  to not be so enrolled.

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

18                          “(i) such individual shall not be eligi-  
19                          ble for benefits under part A of title  
20                          XVIII; and

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

1 care Reform Premium Assistance Program  
2 under paragraph (1).

3 “(1) MEDICARE REFORM PREMIUM ASSISTANCE.—

4 “(1) ESTABLISHMENT OF PREMIUM ASSIST-  
5 ANCE PROGRAM.—The Secretary shall establish a  
6 program to be known as the Medicare Reform Pre-  
7 mium Assistance Program (in this subsection re-  
8 ferred to as the ‘premium assistance program’) con-  
9 sistent with this subsection.

10 “(2) AUTOMATIC ENROLLMENT.—An individual  
11 otherwise entitled under subsection (a) to benefits  
12 under part A of title XVIII shall, subject to sub-  
13 section (k)(4), be enrolled in the premium assistance  
14 program for the period during which such individual  
15 would otherwise be so entitled to benefits.

16 “(3) AMOUNT OF PREMIUM ASSISTANCE.—

17 “(A) IN GENERAL.—Subject to clause (ii),  
18 for each year that an individual is enrolled in  
19 the premium assistance program, the Secretary  
20 shall provide premium assistance to such indi-  
21 vidual in an amount determined by the Sec-  
22 retary that is based on the geographic location  
23 of the individual and the cost of applicable  
24 health insurance coverage and benefits in such  
25 area.

1           “(B) COMPUTATION OF PREMIUM ASSIST-  
2           ANCE AMOUNTS.—The amount of premium as-  
3           sistance provided to an individual located in a  
4           geographic area for a year shall be computed at  
5           120 percent of the sum of the median premium  
6           and median deductible payment for such year  
7           for all health insurance coverage offered by  
8           health insurance issuers in the individual mar-  
9           ket serving such area.

10           “(4) PERMISSIBLE USE OF PREMIUM ASSIST-  
11           ANCE.—Premium assistance under paragraph (3)  
12           may be used only for the following purposes:

13           “(A) For payment of premiums,  
14           deductibles, copayments, or other cost-sharing  
15           for enrollment of such individual for health in-  
16           surance coverage offered by health insurance  
17           issuers in the individual market.

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

22           “(5) MSA DEPOSITS.—The amount of the pre-  
23           mium assistance received by an individual under this  
24           subsection shall be deposited, on behalf of such indi-  
25           vidual, into the MSA plan of such individual.”.

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

## 4 **TITLE IV—EMTALA REFORMS**

### 5 **SEC. 401. EMTALA REFORMS.**

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

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

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

15 “(2) PERMITTING APPLICATION OF ER  
16 TRIAGE.—

17 “(A) IN GENERAL.—The requirement of  
18 paragraph (1) that a hospital conduct an appro-  
19 priate medical screening examination of an indi-  
20 vidual is deemed to be satisfied if a qualified  
21 emergency screener (as defined in subparagraph  
22 (B)) performs a preliminary triage-type screen-  
23 ing in which the personnel—

24 “(i) assesses the nature and extent of  
25 the individual’s illness or injury; and

1                   “(ii) determines, based on such as-  
2                   sessment, that an emergency medical con-  
3                   dition does not exist.

4                   “(B) QUALIFIED EMERGENCY SCREENER  
5                   DEFINED.—In this paragraph, the term ‘quali-  
6                   fied emergency screener’ means a physician, li-  
7                   censed practical nurse or registered nurse,  
8                   qualified emergency medical technician, or other  
9                   individual with basic, health care education that  
10                  meets standards specified by the Secretary as  
11                  being sufficient to perform the screening de-  
12                  scribed in subparagraph (A).”.

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

16                         “(A) a medical condition manifesting itself  
17                         by symptoms of sufficient severity (including se-  
18                         vere pain) and with an onset or of a course  
19                         such that the absence of immediate medical at-  
20                         tention could reasonably be expected to pose an  
21                         immediate risk to life or long-term health of the  
22                         individual (or, with respect to a pregnant  
23                         woman, the life or long-term health of the  
24                         woman or her unborn child); or”.

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

6 **TITLE V—COOPERATIVE GOV-**  
7 **ERNING OF INDIVIDUAL AND**  
8 **GROUP HEALTH INSURANCE**  
9 **COVERAGE**

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

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

15 **“PART D—COOPERATIVE GOVERNING OF INDI-**  
16 **VIDUAL AND GROUP HEALTH INSURANCE**  
17 **COVERAGE**

18 **“SEC. 2795. DEFINITIONS.**

19 “In this part:

20 “(1) PRIMARY STATE.—The term ‘primary  
21 State’ means, with respect to individual or group  
22 health insurance coverage offered by a health insur-  
23 ance issuer, the State designated by the issuer as  
24 the State whose covered laws shall govern the health  
25 insurance issuer in the sale of such coverage under

1       this part. An issuer, with respect to a particular pol-  
2       icy, may only designate one such State as its pri-  
3       mary State with respect to all such coverage it of-  
4       fers. Such an issuer may not change the designated  
5       primary State with respect to individual or group  
6       health insurance coverage once the policy is issued,  
7       except that such a change may be made upon re-  
8       newal of the policy. With respect to such designated  
9       State, the issuer is deemed to be doing business in  
10      that State.

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

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

1           “(4) INDIVIDUAL HEALTH INSURANCE COV-  
2 ERAGE.—The term ‘individual health insurance cov-  
3 erage’ means health insurance coverage offered in  
4 the individual market, as defined in section  
5 2791(e)(1).

6           “(5) GROUP HEALTH INSURANCE COVERAGE.—  
7 The term ‘group health insurance coverage’ has the  
8 meaning given such term in 2791(b)(4).

9           “(6) APPLICABLE STATE AUTHORITY.—The  
10 term ‘applicable State authority’ means, with respect  
11 to a health insurance issuer in a State, the State in-  
12 surance commissioner or official or officials des-  
13 igned by the State to enforce the requirements of  
14 this title for the State with respect to the issuer.

15           “(7) HAZARDOUS FINANCIAL CONDITION.—The  
16 term ‘hazardous financial condition’ means that,  
17 based on its present or reasonably anticipated finan-  
18 cial condition, a health insurance issuer is unlikely  
19 to be able—

20                   “(A) to meet obligations to policyholders  
21 with respect to known claims and reasonably  
22 anticipated claims; or

23                   “(B) to pay other obligations in the normal  
24 course of business.

25           “(8) COVERED LAWS.—

1           “(A) IN GENERAL.—The term ‘covered  
2 laws’ means the laws, rules, regulations, agree-  
3 ments, and orders governing the insurance busi-  
4 ness pertaining to—

5                   “(i) individual or group health insur-  
6 ance coverage issued by a health insurance  
7 issuer;

8                   “(ii) the offer, sale, rating (including  
9 medical underwriting), renewal, and  
10 issuance of individual or group health in-  
11 surance coverage to an individual;

12                   “(iii) the provision to an individual in  
13 relation to individual or group health in-  
14 surance coverage of health care and insur-  
15 ance related services;

16                   “(iv) the provision to an individual in  
17 relation to individual or group health in-  
18 surance coverage of management, oper-  
19 ations, and investment activities of a  
20 health insurance issuer; and

21                   “(v) the provision to an individual in  
22 relation to individual or group health in-  
23 surance coverage of loss control and claims  
24 administration for a health insurance

1 issuer with respect to liability for which  
2 the issuer provides insurance.

3 “(B) EXCEPTION.—Such term does not in-  
4 clude any law, rule, regulation, agreement, or  
5 order governing the use of care or cost manage-  
6 ment techniques, including any requirement re-  
7 lated to provider contracting, network access or  
8 adequacy, health care data collection, or quality  
9 assurance.

10 “(9) STATE.—The term ‘State’ means the 50  
11 States and includes the District of Columbia, Puerto  
12 Rico, the Virgin Islands, Guam, American Samoa,  
13 and the Northern Mariana Islands.

14 “(10) UNFAIR CLAIMS SETTLEMENT PRAC-  
15 TICES.—The term ‘unfair claims settlement prac-  
16 tices’ means only the following practices:

17 “(A) Knowingly misrepresenting to claim-  
18 ants and insured individuals relevant facts or  
19 policy provisions relating to coverage at issue.

20 “(B) Failing to acknowledge with reason-  
21 able promptness pertinent communications with  
22 respect to claims arising under policies.

23 “(C) Failing to adopt and implement rea-  
24 sonable standards for the prompt investigation  
25 and settlement of claims arising under policies.

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

4           “(E) Refusing to pay claims without con-  
5           ducting a reasonable investigation.

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

10          “(G) A pattern or practice of compelling  
11          insured individuals or their beneficiaries to in-  
12          stitute suits to recover amounts due under its  
13          policies by offering substantially less than the  
14          amounts ultimately recovered in suits brought  
15          by them.

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

23          “(I) Attempting to settle or settling claims  
24          on the basis of an application that was materi-

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

3           “(J) Failing to provide forms necessary to  
4           present claims within 15 calendar days of a re-  
5           quests with reasonable explanations regarding  
6           their use.

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

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

15                 “(A) Presenting, causing to be presented  
16                 or preparing with knowledge or belief that it  
17                 will be presented to or by an insurer, a rein-  
18                 surer, broker or its agent, false information as  
19                 part of, in support of or concerning a fact ma-  
20                 terial to one or more of the following:

21                         “(i) An application for the issuance or  
22                         renewal of an insurance policy or reinsur-  
23                         ance contract.

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

1           “(iii) A claim for payment or benefit  
2           pursuant to an insurance policy or reinsur-  
3           ance contract.

4           “(iv) Premiums paid on an insurance  
5           policy or reinsurance contract.

6           “(v) Payments made in accordance  
7           with the terms of an insurance policy or  
8           reinsurance contract.

9           “(vi) A document filed with the com-  
10          missioner or the chief insurance regulatory  
11          official of another jurisdiction.

12          “(vii) The financial condition of an in-  
13          surer or reinsurer.

14          “(viii) The formation, acquisition,  
15          merger, reconsolidation, dissolution or  
16          withdrawal from one or more lines of in-  
17          surance or reinsurance in all or part of a  
18          State by an insurer or reinsurer.

19          “(ix) The issuance of written evidence  
20          of insurance.

21          “(x) The reinstatement of an insur-  
22          ance policy.

23          “(B) Solicitation or acceptance of new or  
24          renewal insurance risks on behalf of an insurer  
25          reinsurer or other person engaged in the busi-

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

5           “(C) Transaction of the business of insur-  
6           ance in violation of laws requiring a license, cer-  
7           tificate of authority or other legal authority for  
8           the transaction of the business of insurance.

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

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

14          “(a) IN GENERAL.—The covered laws of the primary  
15          State shall apply to individual and group health insurance  
16          coverage offered by a health insurance issuer in the pri-  
17          mary State and in any secondary State, but only if the  
18          coverage and issuer comply with the conditions of this sec-  
19          tion with respect to the offering of coverage in any sec-  
20          ondary State.

21          “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
22          ONDARY STATE.—Except as provided in this section, a  
23          health insurance issuer with respect to its offer, sale, rat-  
24          ing (including medical underwriting), renewal, and  
25          issuance of individual or group health insurance coverage

1 in any secondary State is exempt from any covered laws  
2 of the secondary State (and any rules, regulations, agree-  
3 ments, or orders sought or issued by such State under or  
4 related to such covered laws) to the extent that such laws  
5 would—

6 “(1) make unlawful, or regulate, directly or in-  
7 directly, the operation of the health insurance issuer  
8 operating in the secondary State, except that any  
9 secondary State may require such an issuer—

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

15 “(B) to register with and designate the  
16 State insurance commissioner as its agent solely  
17 for the purpose of receiving service of legal doc-  
18 uments or process;

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

24 “(i) the State insurance commissioner  
25 of the primary State has not done an ex-

1           amination within the period recommended  
2           by the National Association of Insurance  
3           Commissioners; and

4                   “(ii) any such examination is con-  
5                   ducted in accordance with the examiners’  
6                   handbook of the National Association of  
7                   Insurance Commissioners and is coordi-  
8                   nated to avoid unjustified duplication and  
9                   unjustified repetition;

10                   “(D) to comply with a lawful order  
11           issued—

12                           “(i) in a delinquency proceeding com-  
13                           menced by the State insurance commis-  
14                           sioner if there has been a finding of finan-  
15                           cial impairment under subparagraph (C);  
16                           or

17                                   “(ii) in a voluntary dissolution pro-  
18                                   ceeding;

19                           “(E) to comply with an injunction issued  
20                   by a court of competent jurisdiction, upon a pe-  
21                   tition by the State insurance commissioner al-  
22                   leging that the issuer is in hazardous financial  
23                   condition;

24                           “(F) to participate, on a nondiscriminatory  
25                   basis, in any insurance insolvency guaranty as-

1           society or similar association to which a  
2           health insurance issuer in the State is required  
3           to belong;

4           “(G) to comply with any State law regard-  
5           ing fraud and abuse (as defined in section  
6           2795(10)), except that if the State seeks an in-  
7           junction regarding the conduct described in this  
8           subparagraph, such injunction must be obtained  
9           from a court of competent jurisdiction;

10          “(H) to comply with any State law regard-  
11          ing unfair claims settlement practices (as de-  
12          fined in section 2795(9)); or

13          “(I) to comply with the applicable require-  
14          ments for independent review under section  
15          2798 with respect to coverage offered in the  
16          State;

17          “(2) require any individual or group health in-  
18          surance coverage issued by the issuer to be  
19          countersigned by an insurance agent or broker resid-  
20          ing in that Secondary State; or

21          “(3) otherwise discriminate against the issuer  
22          issuing insurance in both the primary State and in  
23          any secondary State.

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

1 in 12-point bold type, in any insurance coverage offered  
2 in a secondary State under this part by such a health in-  
3 surance issuer and at renewal of the policy, with the 5  
4 blank spaces therein being appropriately filled with the  
5 name of the health insurance issuer, the name of primary  
6 State, the name of the secondary State, the name of the  
7 secondary State, and the name of the secondary State, re-  
8 spectively, for the coverage concerned: ‘Notice: This policy  
9 is issued by \_\_\_\_\_ and is governed by the laws and  
10 regulations of the State of \_\_\_\_\_, and it has met all  
11 the laws of that State as determined by that State’s De-  
12 partment of Insurance. This policy may be less expensive  
13 than others because it is not subject to all of the insurance  
14 laws and regulations of the State of \_\_\_\_\_, includ-  
15 ing coverage of some services or benefits mandated by the  
16 law of the State of \_\_\_\_\_. Additionally, this policy  
17 is not subject to all of the consumer protection laws or  
18 restrictions on rate changes of the State of \_\_\_\_\_.  
19 As with all insurance products, before purchasing this pol-  
20 icy, you should carefully review the policy and determine  
21 what health care services the policy covers and what bene-  
22 fits it provides, including any exclusions, limitations, or  
23 conditions for such services or benefits.’

24 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
25 AND PREMIUM INCREASES.—

1           “(1) IN GENERAL.—For purposes of this sec-  
2           tion, a health insurance issuer that provides indi-  
3           vidual or group health insurance coverage to an indi-  
4           vidual under this part in a primary or secondary  
5           State may not upon renewal—

6                   “(A) move or reclassify the individual in-  
7                   sured under the health insurance coverage from  
8                   the class such individual is in at the time of  
9                   issue of the contract based on the health status-  
10                  related factors of the individual; or

11                  “(B) increase the premiums assessed the  
12                  individual for such coverage based on a health  
13                  status-related factor or change of a health sta-  
14                  tus-related factor or the past or prospective  
15                  claim experience of the insured individual.

16           “(2) CONSTRUCTION.—Nothing in paragraph  
17           (1) shall be construed to prohibit a health insurance  
18           issuer—

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

22                   “(B) from raising premium rates for all  
23                   policy holders within a class based on claims ex-  
24                   perience;

1           “(C) from changing premiums or offering  
2           discounted premiums to individuals who engage  
3           in wellness activities at intervals prescribed by  
4           the issuer, if such premium changes or incen-  
5           tives—

6                   “(i) are disclosed to the consumer in  
7                   the insurance contract;

8                   “(ii) are based on specific wellness ac-  
9                   tivities that are not applicable to all indi-  
10                  viduals; and

11                  “(iii) are not obtainable by all individ-  
12                  uals to whom coverage is offered;

13                  “(D) from reinstating lapsed coverage; or

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

18           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
19 STATE.—A health insurance issuer may not offer for sale  
20 individual or group health insurance coverage in a sec-  
21 ondary State unless that coverage is currently offered for  
22 sale in the primary State.

23           “(f) LICENSING OF AGENTS OR BROKERS FOR  
24 HEALTH INSURANCE ISSUERS.—Any State may require  
25 that a person acting, or offering to act, as an agent or

1 broker for a health insurance issuer with respect to the  
2 offering of individual or group health insurance coverage  
3 obtain a license from that State, with commissions or  
4 other compensation subject to the provisions of the laws  
5 of that State, except that a State may not impose any  
6 qualification or requirement which discriminates against  
7 a nonresident agent or broker.

8       “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
9 SURANCE COMMISSIONER.—Each health insurance issuer  
10 issuing individual or group health insurance coverage in  
11 both primary and secondary States shall submit—

12           “(1) to the insurance commissioner of each  
13 State in which it intends to offer such coverage, be-  
14 fore it may offer individual or group health insur-  
15 ance coverage in such State—

16                   “(A) a copy of the plan of operation or fea-  
17 sibility study or any similar statement of the  
18 policy being offered and its coverage (which  
19 shall include the name of its primary State and  
20 its principal place of business);

21                   “(B) written notice of any change in its  
22 designation of its primary State; and

23                   “(C) written notice from the issuer of the  
24 issuer’s compliance with all the laws of the pri-  
25 mary State; and

1           “(2) to the insurance commissioner of each sec-  
2           ondary State in which it offers individual or group  
3           health insurance coverage, a copy of the issuer’s  
4           quarterly financial statement submitted to the pri-  
5           mary State, which statement shall be certified by an  
6           independent public accountant and contain a state-  
7           ment of opinion on loss and loss adjustment expense  
8           reserves made by—

9                   “(A) a member of the American Academy  
10                   of Actuaries; or

11                   “(B) a qualified loss reserve specialist.

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

15                   “(1) the solicitation or sale of individual or  
16                   group health insurance coverage by a health insur-  
17                   ance issuer to any person or group who is not eligi-  
18                   ble for such insurance; or

19                   “(2) the solicitation or sale of individual or  
20                   group health insurance coverage that violates the re-  
21                   quirements of the law of a secondary State which  
22                   are described in subparagraphs (A) through (H) of  
23                   section 2796(b)(1).

24           “(i) POWER OF SECONDARY STATES TO TAKE AD-  
25           MINISTRATIVE ACTION.—Nothing in this section shall be

1 construed to affect the authority of any State to enjoin  
2 conduct in violation of that State’s laws described in sec-  
3 tion 2796(b)(1).

4 “(j) STATE POWERS TO ENFORCE STATE LAWS.—

5 “(1) IN GENERAL.—Subject to the provisions of  
6 subsection (b)(1)(G) (relating to injunctions) and  
7 paragraph (2), nothing in this section shall be con-  
8 strued to affect the authority of any State to make  
9 use of any of its powers to enforce the laws of such  
10 State with respect to which a health insurance issuer  
11 is not exempt under subsection (b).

12 “(2) COURTS OF COMPETENT JURISDICTION.—

13 If a State seeks an injunction regarding the conduct  
14 described in paragraphs (1) and (2) of subsection  
15 (h), such injunction must be obtained from a Fed-  
16 eral or State court of competent jurisdiction.

17 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this

18 section shall affect the authority of any State to bring ac-  
19 tion in any Federal or State court.

20 “(l) GENERALLY APPLICABLE LAWS.—Nothing in

21 this section shall be construed to affect the applicability  
22 of State laws generally applicable to persons or corpora-  
23 tions.

24 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO

25 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a

1 health insurance issuer is offering coverage in a primary  
2 State that does not accommodate residents of secondary  
3 States or does not provide a working mechanism for resi-  
4 dents of a secondary State, and the issuer is offering cov-  
5 erage under this part in such secondary State which has  
6 not adopted a qualified high risk pool as its acceptable  
7 alternative mechanism (as defined in section 2744(c)(2)),  
8 the issuer shall, with respect to any individual or group  
9 health insurance coverage offered in a secondary State  
10 under this part, comply with the guaranteed availability  
11 requirements for eligible individuals in section 2741.

12 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
13 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
14 **STATES.**

15 “A health insurance issuer may not offer, sell, or  
16 issue individual or group health insurance coverage in a  
17 secondary State if the State insurance commissioner does  
18 not use a risk-based capital formula for the determination  
19 of capital and surplus requirements for all health insur-  
20 ance issuers.

21 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
22 **DURES.**

23 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-  
24 ance issuer may not offer, sell, or issue individual or group

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

3           “(1) both the secondary State and the primary  
4 State have legislation or regulations in place estab-  
5 lishing an independent review process for individuals  
6 who are covered by individual health insurance cov-  
7 erage or group health insurance offered by a health  
8 insurance issuer, respectively, or

9           “(2) in any case in which the requirements of  
10 subparagraph (A) are not met with respect to the ei-  
11 ther of such States, the issuer provides an inde-  
12 pendent review mechanism substantially identical (as  
13 determined by the applicable State authority of such  
14 State) to that prescribed in the ‘Health Carrier Ex-  
15 ternal Review Model Act’ of the National Association  
16 of Insurance Commissioners for all individuals who  
17 purchase insurance coverage under the terms of this  
18 part, except that, under such mechanism, the review  
19 is conducted by an independent medical reviewer, or  
20 a panel of such reviewers, with respect to whom the  
21 requirements of subsection (b) are met.

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

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

5                   “(A) each independent medical reviewer  
6                   meets the qualifications described in paragraphs  
7                   (2) and (3);

8                   “(B) with respect to each review, each re-  
9                   viewer meets the requirements of paragraph (4)  
10                  and the reviewer, or at least 1 reviewer on the  
11                  panel, meets the requirements described in  
12                  paragraph (5); and

13                  “(C) compensation provided by the issuer  
14                  to each reviewer is consistent with paragraph  
15                  (6).

16           “(2) LICENSURE AND EXPERTISE.—Each inde-  
17           pendent medical reviewer shall be a physician  
18           (allopathic or osteopathic) or health care profes-  
19           sional who—

20                   “(A) is appropriately credentialed or li-  
21                   censed in 1 or more States to deliver health  
22                   care services; and

23                   “(B) typically treats the condition, makes  
24                   the diagnosis, or provides the type of treatment  
25                   under review.

1           “(3) INDEPENDENCE.—

2                   “(A) IN GENERAL.—Subject to subpara-  
3 graph (B), each independent medical reviewer  
4 in a case shall—

5                           “(i) not be a related party (as defined  
6 in paragraph (7));

7                           “(ii) not have a material familial, fi-  
8 nancial, or professional relationship with  
9 such a party; and

10                           “(iii) not otherwise have a conflict of  
11 interest with such a party (as determined  
12 under regulations).

13                   “(B) EXCEPTION.—Nothing in subpara-  
14 graph (A) shall be construed to—

15                           “(i) prohibit an individual, solely on  
16 the basis of affiliation with the issuer,  
17 from serving as an independent medical re-  
18 viewer if—

19                                   “(I) a non-affiliated individual is  
20 not reasonably available;

21                                   “(II) the affiliated individual is  
22 not involved in the provision of items  
23 or services in the case under review;

24                                   “(III) the fact of such an affili-  
25 ation is disclosed to the issuer and the

1 enrollee (or authorized representative)  
2 and neither party objects; and

3 “(IV) the affiliated individual is  
4 not an employee of the issuer and  
5 does not provide services exclusively or  
6 primarily to or on behalf of the issuer;

7 “(ii) prohibit an individual who has  
8 staff privileges at the institution where the  
9 treatment involved takes place from serv-  
10 ing as an independent medical reviewer  
11 merely on the basis of such affiliation if  
12 the affiliation is disclosed to the issuer and  
13 the enrollee (or authorized representative),  
14 and neither party objects; or

15 “(iii) prohibit receipt of compensation  
16 by an independent medical reviewer from  
17 an entity if the compensation is provided  
18 consistent with paragraph (6).

19 “(4) PRACTICING HEALTH CARE PROFESSIONAL  
20 IN SAME FIELD.—

21 “(A) IN GENERAL.—In a case involving  
22 treatment, or the provision of items or serv-  
23 ices—

24 “(i) by a physician, a reviewer shall be  
25 a practicing physician (allopathic or osteo-

1 pathic) of the same or similar specialty, as  
2 a physician who, acting within the appro-  
3 priate scope of practice within the State in  
4 which the service is provided or rendered,  
5 typically treats the condition, makes the  
6 diagnosis, or provides the type of treat-  
7 ment under review; or

8 “(ii) by a non-physician health care  
9 professional, the reviewer, or at least 1  
10 member of the review panel, shall be a  
11 practicing non-physician health care pro-  
12 fessional of the same or similar specialty  
13 as the non-physician health care profes-  
14 sional who, acting within the appropriate  
15 scope of practice within the State in which  
16 the service is provided or rendered, typi-  
17 cally treats the condition, makes the diag-  
18 nosis, or provides the type of treatment  
19 under review.

20 “(B) PRACTICING DEFINED.—For pur-  
21 poses of this paragraph, the term ‘practicing’  
22 means, with respect to an individual who is a  
23 physician or other health care professional, that  
24 the individual provides health care services to

1 individual patients on average at least 2 days  
2 per week.

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

6 “(6) LIMITATIONS ON REVIEWER COMPENSA-  
7 TION.—Compensation provided by the issuer to an  
8 independent medical reviewer in connection with a  
9 review under this section shall—

10 “(A) not exceed a reasonable level; and

11 “(B) not be contingent on the decision ren-  
12 dered by the reviewer.

13 “(7) RELATED PARTY DEFINED.—For purposes  
14 of this section, the term ‘related party’ means, with  
15 respect to a denial of a claim under a coverage relat-  
16 ing to an enrollee, any of the following:

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

19 “(B) The enrollee (or authorized represent-  
20 ative).

21 “(C) The health care professional that pro-  
22 vides the items or services involved in the de-  
23 nial.

1           “(D) The institution at which the items or  
2 services (or treatment) involved in the denial  
3 are provided.

4           “(E) The manufacturer of any drug or  
5 other item that is included in the items or serv-  
6 ices involved in the denial.

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

10          “(8) DEFINITIONS.—For purposes of this sub-  
11 section:

12           “(A) ENROLLEE.—The term ‘enrollee’  
13 means, with respect to health insurance cov-  
14 erage offered by a health insurance issuer, an  
15 individual enrolled with the issuer to receive  
16 such coverage.

17           “(B) HEALTH CARE PROFESSIONAL.—The  
18 term ‘health care professional’ means an indi-  
19 vidual who is licensed, accredited, or certified  
20 under State law to provide specified health care  
21 services and who is operating within the scope  
22 of such licensure, accreditation, or certification.

23 **“SEC. 2799. ENFORCEMENT.**

24          “(a) IN GENERAL.—Subject to subsection (b), with  
25 respect to specific individual or group health insurance

1 coverage the primary State for such coverage has sole ju-  
2 risdiction to enforce the primary State’s covered laws in  
3 the primary State and any secondary State.

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

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

12 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
13 of individual health insurance coverage offered in a sec-  
14 ondary State, or group health insurance covered offered  
15 by a health insurance issuer in a secondary State, that  
16 fails to comply with the covered laws of the primary State,  
17 the applicable State authority of the secondary State may  
18 notify the applicable State authority of the primary  
19 State.”.

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

24 (c) GAO ONGOING STUDY AND REPORTS.—

1           (1) STUDY.—The Comptroller General of the  
2 United States shall conduct an ongoing study con-  
3 cerning the effect of the amendment made by sub-  
4 section (a) on—

5           (A) the number of uninsured and under-in-  
6 sured;

7           (B) the availability and cost of health in-  
8 surance policies for individuals with pre-existing  
9 medical conditions;

10          (C) the availability and cost of health in-  
11 surance policies generally;

12          (D) the elimination or reduction of dif-  
13 ferent types of benefits under health insurance  
14 policies offered in different States; and

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

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