

110TH CONGRESS  
1ST SESSION

# H. R. 2626

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

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 7, 2007

Mr. PRICE of Georgia introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, Education and Labor, Oversight and Government Reform, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

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

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; FINDINGS; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Comprehensive Health Coverage And Reform Enhance-  
6 ment Act of 2007” or as the “Comprehensive  
7 HealthCARE Act of 2007”.

8 (b) FINDINGS.—Congress finds the following:

1           (1) Americans are best served by a health care  
2 system that thrives on and rewards competition,  
3 choice, personal control, affordability, accessibility,  
4 and quality. Now is the time to initiate new policies  
5 that allow innovation to excel and that respond best  
6 to patient's demands, needs, and preferences.

7           (2) In 2005, health care spending in the United  
8 States reached \$2 trillion, and it is projected to  
9 reach \$2.9 trillion in 2009. Health care spending is  
10 projected to reach \$4 trillion by 2015.

11          (3) In 2005, the total national health expendi-  
12 tures rose 6.9 percent—two times the rate of infla-  
13 tion. Total health care spending represented 16 per-  
14 cent of the gross domestic product (GDP).

15          (4) Census data show that 46.6 million Ameri-  
16 cans were uninsured at some point in 2005, an in-  
17 crease of 1.3 million from the comparable number of  
18 uninsured in 2004 (45.3 million). This percentage  
19 rose from 15.6 percent in 2004 to 15.9 percent in  
20 2005.

21          (5) Lack of insurance is much more common  
22 among people with low incomes. Some 24.4 percent  
23 of people with incomes below \$25,000 were unin-  
24 sured in 2005, almost triple the rate of 8.5 percent  
25 among people with incomes over \$75,000.

1           (6) National surveys show that the primary rea-  
2           son people are uninsured is the high cost of health  
3           insurance coverage.

4           (7) The percentage of Americans who are unin-  
5           sured continues to rise due to a decrease of employ-  
6           ees with employer-sponsored coverage.

7           (8) Premiums for employer-based health insur-  
8           ance rose by 7.7 percent in 2006. Small employers  
9           saw their premiums, on average, increase 8.8 per-  
10          cent. Firms with less than 24 workers, experienced  
11          an increase of 10.5 percent.

12          (9) The average employee contribution to com-  
13          pany-provided health insurance has increased more  
14          than 143 percent since 2000. Average out-of-pocket  
15          costs for deductibles, co-payments for medications,  
16          and co-insurance for physician and hospital visits  
17          rose 115 percent during the same period.

18          (10) With our current defined benefit model,  
19          employers determine health benefits, dictate costs  
20          for individuals and families, and hold the contract  
21          with the insurance company.

22          (11) Employer-sponsored defined benefit health  
23          insurance plans have led employees to believe they  
24          are receiving free coverage, while economists have

1 shown that workers forgo higher wages in lieu of  
2 health benefits.

3 (12) Americans pay higher prices for fewer  
4 choices under our current defined benefit model.

5 (13) With both government and employer pro-  
6 vided health care, there is a lack of individual owner-  
7 ship and personal choice for patients.

8 (14) There are 18 million Americans who pur-  
9 chase health insurance on their own and currently,  
10 these individuals pay higher taxes than those who  
11 get insurance through their employer, due to the tax  
12 deductibility allowed to the employer for the pur-  
13 chase of health insurance.

14 (15) Most of the incentives in our current sys-  
15 tem are wrong, causing patients to frequently receive  
16 more tests and procedures than needed

17 (16) Health insurers would be more responsive  
18 to individuals and families if health insurance poli-  
19 cies were owned by the person most directly affected  
20 by the coverage—the patient.

21 (17) Providing individuals and families with  
22 various options to help them secure and maintain  
23 personal, defined contribution coverage of their  
24 choice, would make health care coverage more af-  
25 fordable and accessible for all Americans.

1           (18) It is appropriate to encourage increased ef-  
2           ficiency in the offering of health insurance coverage  
3           through a collaborative approach by the States in  
4           regulating this coverage.

5           (19) Individual health insurance coverage is in-  
6           creasingly offered through the Internet, other elec-  
7           tronic means, and by mail; all of which are inher-  
8           ently part of interstate commerce.

9           (20) The application of numerous and signifi-  
10          cant variations in State law impacts the ability of in-  
11          surers to offer, and individuals to obtain, affordable  
12          individual health insurance coverage, thereby imped-  
13          ing commerce in individual health insurance cov-  
14          erage.

15          (21) Our current civil justice system is ad-  
16          versely affecting patient access to health care serv-  
17          ices, better patient care, and cost-efficient health  
18          care. The health care liability system is a costly and  
19          ineffective mechanism for resolving claims of health  
20          care liability and appropriately compensating injured  
21          patients, and is a deterrent to the sharing of infor-  
22          mation among health care professionals which im-  
23          pedes efforts to improve patient safety and quality  
24          health care.

1           (22) Permitting health care professionals to ne-  
2           gotiate collectively with health care plans will create  
3           a more equal balance of negotiating power, will pro-  
4           mote competition, and will enhance the quality of  
5           patient care.

6           (23) The benefits of an electronic healthcare in-  
7           formation system include improved quality of care,  
8           reduced costs associated with medication errors,  
9           more accurate and complete medical documentation,  
10          more accurate capture of codes and charges, and im-  
11          proved communication among providers enabling  
12          them to respond more quickly to patients' needs and  
13          increase health care quality.

14          (24) To secure access to quality health care it  
15          is essential to have well trained and an appropriate  
16          number of physicians and surgeons to administer  
17          that care.

18          (25) Data shows that median private medical  
19          school tuition and fees has increased by 50 percent  
20          (in real dollars) in the 20 years between 1984 and  
21          2004. Median public medical school tuition and fees  
22          increased by 133 percent over the same time period.

23          (26) The cost of tuition may prevent students  
24          from low-income or minority populations and those

1 with other financial responsibilities from attending  
2 medical school.

3 (27) Students with high debt are less likely to  
4 pursue family practice and primary care specialties  
5 and instead seek specialties with potentially higher  
6 income or more leisure time, which contributes to  
7 the physician shortages all over the country.

8 (28) Emergency medical care is an essential  
9 element of the health care safety net.

10 (29) The Emergency Medical Treatment and  
11 Labor Act (“EMTALA”) requires that all patients  
12 who come to an emergency department be evaluated  
13 and their emergency medical conditions be stabilized,  
14 regardless of the patient’s ability to pay.

15 (30) Nationally, more than 35 percent of emer-  
16 gency department patients are uninsured or are  
17 Medicaid or SCHIP enrollees.

18 (31) Strain on emergency departments is due to  
19 multiple factors, including the shortage of nurses  
20 and on-call physicians, a decrease in the total num-  
21 ber of community hospitals, and high levels of bad  
22 debt incurred as a result of providing care to indi-  
23 gent patients.

24 (32) With the decline in physicians, surgeons,  
25 hospitals, emergency rooms, employer-sponsored

1 health insurance, and the rising number of unin-  
2 sured, the imperative for comprehensive health sys-  
3 tem reform is readily apparent.

4 (33) Patient access to quality care has been  
5 harmed by decreasing compensation to physicians  
6 through a flawed Medicare sustainable growth rate  
7 (SGR) system that fails to appropriately account for  
8 severity of illness, intensity of treatment, medical in-  
9 flation, or costs.

10 (34) Decisions regarding health care are often  
11 the most personal and important made in an individ-  
12 ual's life, however these decisions are increasingly  
13 being made without appropriate input by either pa-  
14 tients or health care providers.

15 (35) Fundamental reform throughout a wide  
16 array of our health care system is required in order  
17 to achieve a 21st century system that is innovative,  
18 responsive, affordable, accessible, accountable, of the  
19 highest quality, and, above all, patient-centered.

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

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

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH  
INSURANCE COVERAGE

Sec. 101. Refundable tax credit for health insurance costs of low-income indi-  
viduals.

Sec. 102. Advance payment of credit as premium payment for qualified health  
insurance.

Sec. 103. Deduction for qualified health insurance costs of individuals.

- Sec. 104. Limitation on employer deduction for group health plan expenses.  
 Sec. 105. Equal employer contribution rule to promote choice.

TITLE II—QUALITY HEALTH-CARE PROFESSIONALS COALITION  
 ACT

- Sec. 201. Short title.  
 Sec. 202. Application of the antitrust laws to health care professionals negotiating with health plans.

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

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

TITLE IV—HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY  
 HEALTHCARE (HEALTH) ACT OF 2007

- Sec. 401. Short title.  
 Sec. 402. Findings and purpose.  
 Sec. 403. Encouraging speedy resolution of claims.  
 Sec. 404. Compensating patient injury.  
 Sec. 405. Maximizing patient recovery.  
 Sec. 406. Additional HEALTH benefits.  
 Sec. 407. Punitive damages.  
 Sec. 408. Authorization of payment of future damages to claimants in HEALTH care lawsuits.  
 Sec. 409. Definitions.  
 Sec. 410. Effect on other laws.  
 Sec. 411. State flexibility and protection of States' rights.  
 Sec. 412. Applicability; effective date.  
 Sec. 413. Sense of Congress.  
 Sec. 414. State grants to create administrative health care tribunals.

TITLE V—TAX CREDIT FOR HEALTH INFORMATION  
 TECHNOLOGY

- Sec. 501. Purchase of qualified health care information technology.  
 Sec. 502. Telecommunications credit for qualified medical care providers.  
 Sec. 503. Development of health care information technology standards.

TITLE VI—MEDICAL LIABILITY REFORMS

- Sec. 601. Constitutional authority.  
 Sec. 602. Protection against legal liability for emergency and related services furnished to any individual.

TITLE VII—TAX DEDUCTION FOR UNCOMPENSATED CARE IN  
 EMERGENCY ROOMS

- Sec. 701. Bad debt deduction for doctors to partially offset the cost of providing uncompensated care required to be provided under amendments made by the Emergency Medical Treatment and Labor Act.

TITLE VIII—ADDITIONAL CHANGES

- Sec. 801. Application of section 1115 waivers by other States.  
 Sec. 802. HIPAA Technical Advisory Group.

- Sec. 803. Medicare physician payment update reform.  
 Sec. 804. Removing limitations on balance billing with beneficiary notice for highest income beneficiaries.  
 Sec. 805. Election of tax credit instead of alternative government benefits.  
 Sec. 806. Use of private contracts by medicare beneficiaries for professional services.  
 Sec. 807. EMTALA Technical Advisory Group.  
 Sec. 808. Federally-Supported Student Loan Funds for Medical Students.  
 Sec. 809. Establishment of performance-based quality measures.

1 **TITLE I—TAX INCENTIVES FOR**  
 2 **MAINTAINING HEALTH IN-**  
 3 **SURANCE COVERAGE**

4 **SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSUR-**  
 5 **ANCE COSTS OF LOW-INCOME INDIVIDUALS.**

6 (a) IN GENERAL.—Subpart C of subchapter A of  
 7 chapter 1 of the Internal Revenue Code of 1986 (relating  
 8 to refundable credits) is amended by redesignating section  
 9 36 as section 37 and by inserting after section 35 the fol-  
 10 lowing new section:

11 **“SEC. 36. HEALTH INSURANCE COSTS OF LOW-INCOME IN-**  
 12 **DIVIDUALS.**

13 “(a) IN GENERAL.—In the case of an individual,  
 14 there shall be allowed as a credit against the tax imposed  
 15 by subtitle A the aggregate amount paid by the taxpayer  
 16 for coverage of the taxpayer and the taxpayer’s qualifying  
 17 family members under qualified health insurance for eligi-  
 18 ble coverage months beginning in the taxable year.

19 “(b) LIMITATIONS.—

20 “(1) IN GENERAL.—The amount allowable as a  
 21 credit under subsection (a) for the taxable year shall

1 not exceed the sum of the monthly limitations for  
2 months during such taxable year that the taxpayer  
3 or the taxpayer's qualifying family members is an el-  
4 igible individual.

5 “(2) MONTHLY LIMITATION.—The monthly lim-  
6 itation for any month is the credit percentage of  $\frac{1}{12}$   
7 of the sum of—

8 “(A) \$4,000 for coverage of the taxpayer,

9 “(B) in the case of a joint return, \$4,000  
10 for coverage of the taxpayer's spouse, and

11 “(C) \$2,000 for coverage of each depend-  
12 ent of the taxpayer.

13 “(3) CREDIT PERCENTAGE.—

14 “(A) IN GENERAL.—For purposes of this  
15 section, the term ‘credit percentage’ means 90  
16 percent reduced by 1 percentage point for each  
17 \$1,000 (or fraction thereof) by which the tax-  
18 payer's adjusted gross income for the taxable  
19 year exceeds the threshold amount.

20 “(B) THRESHOLD AMOUNT.—For purposes  
21 of this paragraph, the term ‘threshold amount’  
22 means, with respect to any taxpayer for any  
23 taxable year, the sum of—

24 “(i) \$20,000,

1                   “(ii) in the case of a joint return,  
2                   \$6,000, and

3                   “(iii) \$5,000 for each dependent of  
4                   the taxpayer.

5                   “(4) ONLY 2 DEPENDENTS TAKEN INTO AC-  
6                   COUNT.—Not more than 2 dependents of the tax-  
7                   payer may be taken into account under paragraphs  
8                   (2)(C) and (3)(B)(iii).

9                   “(5) INFLATION ADJUSTMENT.—In the case of  
10                  any taxable year beginning in a calendar year after  
11                  2009, each dollar amount contained in paragraph  
12                  (2) or (3) shall be increased by an amount equal  
13                  to—

14                         “(A) such dollar amount, multiplied by

15                         “(B) the cost-of-living adjustment deter-  
16                         mined under section 1(f)(3) for the calendar  
17                         year in which the taxable year begins, deter-  
18                         mined by substituting ‘calendar year 2008’ for  
19                         ‘calendar year 1992’ in subparagraph (B)  
20                         thereof.

21                  Any increase determined under the preceding sen-  
22                  tence shall be rounded to the nearest multiple of  
23                  \$50.

24                   “(c) ELIGIBLE COVERAGE MONTH.—For purposes of  
25                  this section, the term ‘eligible coverage month’ means,

1 with respect to any individual, any month if, as of the first  
2 day of such month, the individual—

3 “(1) is covered by qualified health insurance,

4 “(2) does not have other specified coverage, and

5 “(3) is not imprisoned under Federal, State, or  
6 local authority.

7 “(d) QUALIFYING FAMILY MEMBER.—For purposes  
8 of this section, the term ‘qualifying family member’  
9 means—

10 “(1) in the case of a joint return, the taxpayer’s  
11 spouse, and

12 “(2) any dependent of the taxpayer.

13 “(e) QUALIFIED HEALTH INSURANCE.—

14 “(1) IN GENERAL.—For purposes of this sec-  
15 tion, the term ‘qualified health insurance’ means any  
16 insurance which constitutes medical care.

17 “(2) EXCEPTIONS.—Such term does not include  
18 insurance—

19 “(A) substantially all of the coverage of  
20 which is of excepted benefits described in sec-  
21 tion 9832(e); or

22 “(B) offered in the individual market (as  
23 defined in paragraph (1) of section 2791(e) of  
24 the Public Health Service Act) or small group  
25 market (as defined in paragraph (5) of such

1 section) unless the insurance meets the require-  
2 ments of paragraph (3).

3 “(3) INSURANCE REQUIREMENTS.—For pur-  
4 poses of paragraph (2)(B), the requirements of this  
5 paragraph with respect to insurance are the fol-  
6 lowing:

7 “(A) The issuer of the insurance may not  
8 decline to offer the insurance, or deny enroll-  
9 ment, of any individual based on any factor de-  
10 scribed in section 9802(a)(1).

11 “(B) The insurance conforms to standards  
12 (established by the National Association of In-  
13 surance Commissioners in consultation with in-  
14 surance companies and recognized by the Sec-  
15 retary) relating to each of the following:

16 “(i) Limitation on application of pre-  
17 existing condition exclusions (as defined in  
18 section 9801(b)(1)).

19 “(ii) Guaranteed renewability.

20 “(iii) Premium ratings.

21 “(iv) Risk-spreading.

22 “(v) Consumer disclosures.

23 “(vi) Information provided to States  
24 and the Federal Government.

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

4               “(1) COVERAGE UNDER MEDICARE, MEDICAID,  
5 OR SCHIP.—Such individual—

6                       “(A) is entitled to benefits under part A of  
7 title XVIII of the Social Security Act or is en-  
8 rolled under part B of such title, or

9                       “(B) is enrolled in the program under title  
10 XIX or XXI of such Act (other than under sec-  
11 tion 1928 of such Act).

12               “(2) CERTAIN OTHER COVERAGE.—Such indi-  
13 vidual—

14                       “(A) is enrolled in a health benefits plan  
15 under chapter 89 of title 5, United States Code,  
16 or

17                       “(B) is entitled to receive benefits under  
18 chapter 55 of title 10, United States Code.

19       “(g) SPECIAL RULES.—

20               “(1) COORDINATION WITH ADVANCE PAYMENTS  
21 OF CREDIT; RECAPTURE OF EXCESS ADVANCE PAY-  
22 MENTS.—With respect to any taxable year—

23                       “(A) the amount which would (but for this  
24 subsection) be allowed as a credit to the tax-  
25 payer under subsection (a) shall be reduced

1 (but not below zero) by the aggregate amount  
2 paid on behalf of such taxpayer under section  
3 7529 for months beginning in such taxable  
4 year, and

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

8 “(i) the aggregate amount paid on be-  
9 half of such taxpayer under section 7529  
10 for months beginning in such taxable year,  
11 over

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

15 “(2) COORDINATION WITH OTHER DEDUC-  
16 TIONS.—Amounts taken into account under sub-  
17 section (a) shall not be taken into account in deter-  
18 mining—

19 “(A) any deduction allowed under section  
20 162(l), 213, or 224, or

21 “(B) any credit allowed under section 35.

22 “(3) MEDICAL AND HEALTH SAVINGS AC-  
23 COUNTS.—Amounts distributed from an Archer  
24 MSA (as defined in section 220(d)) or from a health

1 savings account (as defined in section 223(d)) shall  
2 not be taken into account under subsection (a).

3 “(4) DENIAL OF CREDIT TO DEPENDENTS AND  
4 NONPERMANENT RESIDENT ALIEN INDIVIDUALS .—  
5 No credit shall be allowed under this section to any  
6 individual who is—

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

10 “(B) a dependent with respect to another  
11 taxpayer for a taxable year beginning in the  
12 calendar year in which such individual’s taxable  
13 year begins.

14 “(5) INSURANCE WHICH COVERS OTHER INDI-  
15 VIDUALS.—For purposes of this section, rules simi-  
16 lar to the rules of section 213(d)(6) shall apply with  
17 respect to any contract for qualified health insurance  
18 under which amounts are payable for coverage of an  
19 individual other than the taxpayer and qualifying  
20 family members.

21 “(6) TREATMENT OF PAYMENTS.—For pur-  
22 poses of this section—

23 “(A) PAYMENTS BY SECRETARY.—Pay-  
24 ments made by the Secretary on behalf of any  
25 individual under section 7529 (relating to ad-

1 vance payment of credit for health insurance  
2 costs of low-income individuals) shall be treated  
3 as having been made by the taxpayer on the  
4 first day of the month for which such payment  
5 was made.

6 “(B) PAYMENTS BY TAXPAYER.—Pay-  
7 ments made by the taxpayer for eligible cov-  
8 erage months shall be treated as having been  
9 made by the taxpayer on the first day of the  
10 month for which such payment was made.

11 “(7) REGULATIONS.—The Secretary may pre-  
12 scribe such regulations and other guidance as may  
13 be necessary or appropriate to carry out this section,  
14 section 6050W, and section 7529.”

15 (b) CONFORMING AMENDMENTS.—

16 (1) Paragraph (2) of section 1324(b) of title  
17 31, United States Code, is amended by inserting “or  
18 section 36” after “section 35”.

19 (2) The table of sections for subpart C of part  
20 IV of subchapter A of chapter 1 of the Internal Rev-  
21 enue Code of 1986 is amended by redesignating the  
22 item relating to section 36 as an item relating to  
23 section 37 and by inserting after the item relating  
24 to section 35 the following new item:

“Sec. 36. Health insurance costs of low-income individuals.”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2008.

4 **SEC. 102. ADVANCE PAYMENT OF CREDIT AS PREMIUM**  
5 **PAYMENT FOR QUALIFIED HEALTH INSUR-**  
6 **ANCE.**

7 (a) IN GENERAL.—Chapter 77 of the Internal Rev-  
8 enue Code of 1986 (relating to miscellaneous provisions)  
9 is amended by adding at the end the following:

10 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT AS PREMIUM**  
11 **PAYMENT FOR QUALIFIED HEALTH INSUR-**  
12 **ANCE.**

13 “Not later than January 1, 2009, the Secretary shall  
14 establish a program for making payments to providers of  
15 qualified health insurance (as defined in section 36(e)) on  
16 behalf of taxpayers eligible for the credit under section 36.  
17 Except as otherwise provided by the Secretary, such pay-  
18 ments shall be made on the basis of the adjusted gross  
19 income of the taxpayer for the preceding taxable year.”.

20 (b) DISCLOSURE OF RETURN INFORMATION FOR  
21 PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PRE-  
22 MIUMS FOR QUALIFIED HEALTH INSURANCE.—

23 (1) IN GENERAL.—Subsection (1) of section  
24 6103 of such Code is amended by adding at the end  
25 the following new paragraph:

1           “(21) DISCLOSURE OF RETURN INFORMATION  
2           FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT  
3           AS PREMIUMS FOR QUALIFIED HEALTH INSUR-  
4           ANCE.—The Secretary may, on behalf of taxpayers  
5           eligible for the credit under section 36, disclose to a  
6           provider of qualified health insurance (as defined in  
7           section 36(e)), and persons acting on behalf of such  
8           provider, return information with respect to any  
9           such taxpayer only to the extent necessary (as pre-  
10          scribed by regulations issued by the Secretary) to  
11          carry out the program established by section 7529  
12          (relating to advance payment of credit as premium  
13          payment for qualified health insurance).”.

14           (2) CONFIDENTIALITY OF INFORMATION.—  
15          Paragraph (3) of section 6103(a) of such Code is  
16          amended by striking “or (20)” and inserting “(20),  
17          or (21)”.

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

21          (c) INFORMATION REPORTING.—

22           (1) IN GENERAL.—Subpart B of part III of  
23          subchapter A of chapter 61 of such Code (relating  
24          to information concerning transactions with other

1 persons) is amended by adding at the end the fol-  
2 lowing new section:

3 **“SEC. 6050W. RETURNS RELATING TO CREDIT FOR HEALTH**  
4 **INSURANCE COSTS OF LOW-INCOME INDIVID-**  
5 **UALS.**

6 “(a) REQUIREMENT OF REPORTING.—Every person  
7 who is entitled to receive payments for any month of any  
8 calendar year under section 7529 (relating to advance pay-  
9 ment of credit as premium payment for qualified health  
10 insurance) with respect to any individual shall, at such  
11 time as the Secretary may prescribe, make the return de-  
12 scribed in subsection (b) with respect to each such indi-  
13 vidual.

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

16 “(1) is in such form as the Secretary may pre-  
17 scribe, and

18 “(2) contains—

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

21 “(B) the number of months for which  
22 amounts were entitled to be received with re-  
23 spect to such individual under section 7529 (re-  
24 lating to advance payment of credit as premium  
25 payment for qualified health insurance),

1           “(C) the amount entitled to be received for  
2           each such month, and

3           “(D) such other information as the Sec-  
4           retary may prescribe.

5           “(c) STATEMENTS TO BE FURNISHED TO INDIVID-  
6           UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
7           QUIRED.—Every person required to make a return under  
8           subsection (a) shall furnish to each individual whose name  
9           is required to be set forth in such return a written state-  
10          ment showing—

11           “(1) the name and address of the person re-  
12          quired to make such return and the phone number  
13          of the information contact for such person, and

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

16          The written statement required under the preceding sen-  
17          tence shall be furnished on or before January 31 of the  
18          year following the calendar year for which the return  
19          under subsection (a) is required to be made.”.

20           (2) ASSESSABLE PENALTIES.—

21           (A) Subparagraph (B) of section  
22           6724(d)(1) of such Code (relating to defini-  
23           tions) is amended by striking “or” at the end  
24           of clause (xix), by striking “and” at the end of

1 clause (xx) and inserting “or”, and by inserting  
 2 after clause (xx) the following new clause:

3 “(xxi) section 6050W (relating to re-  
 4 turns relating to credit for health insur-  
 5 ance costs of low-income individuals),  
 6 and”.

7 (B) Paragraph (2) of section 6724(d) of  
 8 such Code is amended by striking “or” at the  
 9 end of subparagraph (BB), by striking the pe-  
 10 riod at the end of subparagraph (CC) and in-  
 11 serting “, or”, and by adding after subpara-  
 12 graph (CC) the following new subparagraph:

13 “(DD) section 6050W (relating to returns  
 14 relating to credit for health insurance costs of  
 15 low-income individuals).”.

16 (d) CLERICAL AMENDMENTS.—

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

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

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

“Sec. 6050W. Returns relating to credit for health insurance costs of low-in-  
 come individuals.”.

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

4 **SEC. 103. DEDUCTION FOR QUALIFIED HEALTH INSURANCE**  
5 **COSTS OF INDIVIDUALS.**

6 (a) IN GENERAL.—Part VII of subchapter B of chap-  
7 ter 1 of the Internal Revenue Code of 1986 (relating to  
8 additional itemized deductions) is amended by redesignig-  
9 nating section 224 as section 225 and by inserting after  
10 section 223 the following new section:

11 **“SEC. 224. COSTS OF QUALIFIED HEALTH INSURANCE.**

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

17 “(b) QUALIFIED HEALTH INSURANCE.—For pur-  
18 poses of this section, the term ‘qualified health insurance’  
19 means insurance which constitutes medical care; except  
20 that such term shall not include any insurance if substan-  
21 tially all of its coverage is of excepted benefits described  
22 in section 9832(e).

23 “(c) SPECIAL RULES.—

24 “(1) COORDINATION WITH MEDICAL DEDUC-  
25 TION, ETC.—Any amount paid by a taxpayer for in-

1       surance to which subsection (a) applies shall not be  
2       taken into account in computing the amount allow-  
3       able to the taxpayer as a deduction under section  
4       162(l) or 213(a). Any amount taken into account in  
5       determining the credit allowed under section 35 shall  
6       not be taken into account for purposes of this sec-  
7       tion.

8               “(2) DEDUCTION NOT ALLOWED FOR SELF-EM-  
9       EMPLOYMENT TAX PURPOSES.—The deduction allow-  
10      able by reason of this section shall not be taken into  
11      account in determining an individual’s net earnings  
12      from self-employment (within the meaning of section  
13      1402(a)) for purposes of chapter 2.”.

14      (b) DEDUCTION ALLOWED IN COMPUTING AD-  
15      JUSTED GROSS INCOME.—Subsection (a) of section 62 of  
16      such Code is amended by inserting before the last sentence  
17      the following new paragraph:

18               “(22) COSTS OF QUALIFIED HEALTH INSUR-  
19      ANCE.—The deduction allowed by section 224.”.

20      (c) CLERICAL AMENDMENT.—The table of sections  
21      for part VII of subchapter B of chapter 1 of such Code  
22      is amended by redesignating the item relating to section  
23      224 as an item relating to section 225 and inserting before  
24      such item the following new item:

“Sec. 224. Costs of qualified health insurance.”.

1 (d) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to taxable years beginning after  
 3 December 31, 2008.

4 **SEC. 104. LIMITATION ON EMPLOYER DEDUCTION FOR**  
 5 **GROUP HEALTH PLAN EXPENSES.**

6 (a) IN GENERAL.—Section 162 of the Internal Rev-  
 7 enue Code of 1986 is amended by redesignating subsection  
 8 (q) as subsection (r) and by inserting after subsection (o)  
 9 the following new subsection:

10 “(q) LIMITATION ON DEDUCTION FOR GROUP  
 11 HEALTH PLAN EXPENSES.—The deduction allowed for  
 12 any taxable year under this section for any amount paid  
 13 or incurred in connection with a group health plan (as de-  
 14 fined in subsection (n)(3)) shall not exceed the sum of—  
 15 “(1) \$15,000 for each contract for family cov-  
 16 erage under such plan, and  
 17 “(2) \$7,500 for each contract for self-only cov-  
 18 erage under such plan.”.

19 (b) EFFECTIVE DATE.—The amendment made by  
 20 this section shall apply to taxable years beginning after  
 21 December 31, 2008.

22 **SEC. 105. EQUAL EMPLOYER CONTRIBUTION RULE TO PRO-**  
 23 **MOTE CHOICE.**

24 (a) EXCISE TAX FOR FAILURE TO PROVIDE CON-  
 25 TRIBUTION ELECTION.—

1           (1) IN GENERAL.—Chapter 47 of the Internal  
2           Revenue Code of 1986 is amended by inserting after  
3           section 5000 the following new section:

4   **“SEC. 5000A. HEALTH CARE CONTRIBUTION ELECTION.**

5           “(a) IMPOSITION OF TAX.—There is hereby imposed  
6           on any employer or employee organization that contributes  
7           to a group health plan and fails to meet the requirement  
8           of subsection (b) with respect to any individual eligible to  
9           participate in such plan (determined under the terms of  
10          the plan and without regard to the election described in  
11          subsection (b)) a tax equal to 3 times the contribution  
12          amount with respect to the individual.

13          “(b) CONTRIBUTION ELECTION.—The requirement  
14          of this subsection is met with respect to any individual  
15          if such individual may elect to have the employer or em-  
16          ployee organization pay an amount which is not less than  
17          the contribution amount to any provider of insurance  
18          (other than insurance described in section 36(e)(2)) which  
19          constitutes medical care of the individual or individual’s  
20          spouse or dependents in lieu of any group health plan cov-  
21          erage otherwise provided or contributed to by the employer  
22          with respect to such individual.

23          “(c) CONTRIBUTION AMOUNT.—For purposes of this  
24          section, the term ‘contribution amount’ means, with re-  
25          spect to an individual under a group health plan, the por-

1 tion of the applicable premium of such individual under  
2 such plan (as determined under section 4980B(f)(4))  
3 which is not paid by the individual.

4 “(d) GROUP HEALTH PLAN.—For purpose of this  
5 section, the term ‘group health plan’ has the meaning  
6 given to such term by section 5000(b)(1) and determined  
7 without regard to section 5000(d).

8 “(e) APPLICATION TO FEHBP.—Notwithstanding  
9 any other provision of law, the Office of Personnel Man-  
10 agement shall carry out the health benefits program under  
11 chapter 89 of title 5, United States Code, consistent with  
12 the requirements of this section.”.

13 (2) CLERICAL AMENDMENT.—The table of sec-  
14 tions for chapter 47 of such Code is amended by in-  
15 serting after the item relating to section 5000 the  
16 following new item:

“Sec. 5000A. Health care contribution election.”.

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

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

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

4           “(2) the aggregate amount of such contribu-  
5           tions is estimated to be equal to the aggregate  
6           amount of such contributions if this subsection did  
7           not apply.”.

8           (c) ERISA CONFORMING AMENDMENT.—Section  
9           404 of the Employee Retirement Income Security Act of  
10          1974 (29 U.S.C. 1104) is amended by adding at the end  
11          the following new subsection:

12          “(e) An employer which provides benefits to employ-  
13          ees consisting of health insurance coverage, benefits other-  
14          wise consisting of medical care, or both, shall not be treat-  
15          ed as breaching any of the responsibilities, obligations, or  
16          duties imposed upon fiduciaries by this title in the case  
17          of one or more of such employees solely because of the  
18          extent to which the employer elects to provide, in the case  
19          of such one or more employees, some or all of such benefits  
20          by means of contributions made under an arrangement  
21          which is not a group health plan, irrespective of the extent  
22          to which the employer otherwise provides such benefits to  
23          employees under a group health plan. For purposes of this  
24          subsection, terms used in this subsection which are defined

1 in section 733 shall have the definitions provided such  
2 terms in such section.”.

3 **TITLE II—QUALITY HEALTH-**  
4 **CARE PROFESSIONALS COA-**  
5 **LITION ACT**

6 **SEC. 201. SHORT TITLE.**

7 This title may be cited as the “Quality Health-Care  
8 Coalition Act of 2007”.

9 **SEC. 202. APPLICATION OF THE ANTITRUST LAWS TO**  
10 **HEALTH CARE PROFESSIONALS NEGOTI-**  
11 **ATING WITH HEALTH PLANS.**

12 (a) IN GENERAL.—Any health care professionals who  
13 are engaged in negotiations with a health plan regarding  
14 the terms of any contract under which the professionals  
15 provide health care items or services for which benefits  
16 are provided under such plan shall, in connection with  
17 such negotiations, be entitled to the same treatment under  
18 the antitrust laws as the treatment to which bargaining  
19 units which are recognized under the National Labor Rela-  
20 tions Act are entitled in connection with such collective  
21 bargaining. Such a professional shall, only in connection  
22 with such negotiations, be treated as an employee engaged  
23 in concerted activities and shall not be regarded as having  
24 the status of an employer, independent contractor, mana-  
25 gerial employee, or supervisor.

1 (b) PROTECTION FOR GOOD FAITH ACTIONS.—Ac-  
2 tions taken in good faith reliance on subsection (a) shall  
3 not be the subject under the antitrust laws of criminal  
4 sanctions nor of any civil damages, fees, or penalties be-  
5 yond actual damages incurred.

6 (c) LIMITATION.—

7 (1) NO NEW RIGHT FOR COLLECTIVE CES-  
8 SATION OF SERVICE.—The exemption provided in  
9 subsection (a) shall not confer any new right to par-  
10 ticipate in any collective cessation of service to pa-  
11 tients not already permitted by existing law.

12 (2) NO CHANGE IN NATIONAL LABOR RELA-  
13 TIONS ACT.—This section applies only to health care  
14 professionals excluded from the National Labor Re-  
15 lations Act. Nothing in this section shall be con-  
16 strued as changing or amending any provision of the  
17 National Labor Relations Act, or as affecting the  
18 status of any group of persons under that Act.

19 (d) 5-YEAR SUNSET.—The exemption provided in  
20 subsection (a) shall only apply to conduct occurring during  
21 the 5-year period beginning on the date of the enactment  
22 of this Act and shall continue to apply for 1 year after  
23 the end of such period to contracts entered into before  
24 the end of such period.

1           (e) LIMITATION ON EXEMPTION.—Nothing in this  
2 section shall exempt from the application of the antitrust  
3 laws any agreement or otherwise unlawful conspiracy that  
4 excludes, limits the participation or reimbursement of, or  
5 otherwise limits the scope of services to be provided by  
6 any health care professional or group of health care pro-  
7 fessionals with respect to the performance of services that  
8 are within their scope of practice as defined or permitted  
9 by relevant law or regulation.

10           (f) NO EFFECT ON TITLE VI OF CIVIL RIGHTS ACT  
11 OF 1964.—Nothing in this section shall be construed to  
12 affect the application of title VI of the Civil Rights Act  
13 of 1964.

14           (g) NO APPLICATION TO FEDERAL PROGRAMS.—  
15 Nothing in this section shall apply to negotiations between  
16 health care professionals and health plans pertaining to  
17 benefits provided under any of the following:

18                   (1) The Medicare Program under title XVIII of  
19 the Social Security Act (42 U.S.C. 1395 et seq.).

20                   (2) The Medicaid Program under title XIX of  
21 the Social Security Act (42 U.S.C. 1396 et seq.).

22                   (3) The SCHIP program under title XXI of the  
23 Social Security Act (42 U.S.C. 1397aa et seq.).

1           (4) Chapter 55 of title 10, United States Code  
2           (relating to medical and dental care for members of  
3           the uniformed services).

4           (5) Chapter 17 of title 38, United States Code  
5           (relating to Veterans' medical care).

6           (6) Chapter 89 of title 5, United States Code  
7           (relating to the Federal employees' health benefits  
8           program).

9           (7) The Indian Health Care Improvement Act  
10          (25 U.S.C. 1601 et seq.).

11          (h) EXEMPTION OF ABORTION AND ABORTION SERV-  
12 ICES.—Nothing in this section shall apply to negotiations  
13 specifically relating to requiring a health plan to cover  
14 abortion or abortion services.

15          (i) GENERAL ACCOUNTING OFFICE STUDY AND RE-  
16 PORT.—The Comptroller General of the United States  
17 shall conduct a study on the impact of enactment of this  
18 section during the 12-month period beginning with the  
19 fifth year of the 5-year period described in subsection (d).  
20 Not later than the end of such 12-month period the Comp-  
21 troller General shall submit to Congress a report on such  
22 study and shall include in the report such recommenda-  
23 tions on the extension of this section (and changes that  
24 should be made in making such extension) as the Comp-  
25 troller General deems appropriate.

1 (j) DEFINITIONS.—For purposes of this section:

2 (1) ANTITRUST LAWS.—The term “antitrust  
3 laws”—

4 (A) has the meaning given it in subsection  
5 (a) of the first section of the Clayton Act (15  
6 U.S.C. 12(a)), except that such term includes  
7 section 5 of the Federal Trade Commission Act  
8 (15 U.S.C. 45) to the extent such section 5 ap-  
9 plies to unfair methods of competition; and

10 (B) includes any State law similar to the  
11 laws referred to in subparagraph (A).

12 (2) HEALTH PLAN AND RELATED TERMS.—

13 (A) IN GENERAL.—The term “health plan”  
14 means a group health plan or a health insur-  
15 ance issuer that is offering health insurance  
16 coverage.

17 (B) HEALTH INSURANCE COVERAGE;  
18 HEALTH INSURANCE ISSUER.—The terms  
19 “health insurance coverage” and “health insur-  
20 ance issuer” have the meanings given such  
21 terms under paragraphs (1) and (2), respec-  
22 tively, of section 733(b) of the Employee Retire-  
23 ment Income Security Act of 1974 (29 U.S.C.  
24 1191b(b)).

1 (C) GROUP HEALTH PLAN.—The term  
2 “group health plan” has the meaning given that  
3 term in section 733(a)(1) of the Employee Re-  
4 tirement Income Security Act of 1974 (29  
5 U.S.C. 1191b(a)(1)).

6 (3) HEALTH CARE PROFESSIONAL.—The term  
7 “health care professional” means an individual who  
8 provides health care items or services, treatment, as-  
9 sistance with activities of daily living, or medications  
10 to patients and who, to the extent required by State  
11 or Federal law, possesses specialized training that  
12 confers expertise in the provision of such items or  
13 services, treatment, assistance, or medications.

14 (k) SENSE OF THE CONGRESS.—It is the sense of  
15 the Congress that decisions regarding medical care and  
16 treatment should be made by the physician or health care  
17 professional in consultation with the patient.

18 **TITLE III—INTERSTATE MARKET**  
19 **FOR HEALTH INSURANCE**

20 **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**  
21 **HEALTH INSURANCE COVERAGE.**

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

1           **“PART D—COOPERATIVE GOVERNING OF**  
2           **INDIVIDUAL HEALTH INSURANCE COVERAGE**

3           **“SEC. 2795. DEFINITIONS.**

4           “In this part:

5                   “(1) PRIMARY STATE.—The term ‘primary  
6           State’ means, with respect to individual health insur-  
7           ance coverage offered by a health insurance issuer,  
8           the State designated by the issuer as the State  
9           whose covered laws shall govern the health insurance  
10          issuer in the sale of such coverage under this part.  
11          An issuer, with respect to a particular policy, may  
12          only designate one such State as its primary State  
13          with respect to all such coverage it offers. Such an  
14          issuer may not change the designated primary State  
15          with respect to individual health insurance coverage  
16          once the policy is issued, except that such a change  
17          may be made upon renewal of the policy. With re-  
18          spect to such designated State, the issuer is deemed  
19          to be doing business in that State.

20                   “(2) SECONDARY STATE.—The term ‘secondary  
21          State’ means, with respect to individual health insur-  
22          ance coverage offered by a health insurance issuer,  
23          any State that is not the primary State. In the case  
24          of a health insurance issuer that is selling a policy  
25          in, or to a resident of, a secondary State, the issuer

1 is deemed to be doing business in that secondary  
2 State.

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

9 “(4) INDIVIDUAL HEALTH INSURANCE COV-  
10 ERAGE.—The term ‘individual health insurance cov-  
11 erage’ means health insurance coverage offered in  
12 the individual market, as defined in section  
13 2791(e)(1).

14 “(5) APPLICABLE STATE AUTHORITY.—The  
15 term ‘applicable State authority’ means, with respect  
16 to a health insurance issuer in a State, the State in-  
17 surance commissioner or official or officials des-  
18 ignated by the State to enforce the requirements of  
19 this title for the State with respect to the issuer.

20 “(6) HAZARDOUS FINANCIAL CONDITION.—The  
21 term ‘hazardous financial condition’ means that,  
22 based on its present or reasonably anticipated finan-  
23 cial condition, a health insurance issuer is unlikely  
24 to be able—

1           “(A) to meet obligations to policyholders  
2 with respect to known claims and reasonably  
3 anticipated claims; or

4           “(B) to pay other obligations in the normal  
5 course of business.

6           “(7) COVERED LAWS.—

7           “(A) IN GENERAL.—The term ‘covered  
8 laws’ means the laws, rules, regulations, agree-  
9 ments, and orders governing the insurance busi-  
10 ness pertaining to—

11           “(i) individual health insurance cov-  
12 erage issued by a health insurance issuer;

13           “(ii) the offer, sale, rating (including  
14 medical underwriting), renewal, and  
15 issuance of individual health insurance cov-  
16 erage to an individual;

17           “(iii) the provision to an individual in  
18 relation to individual health insurance cov-  
19 erage of health care and insurance related  
20 services;

21           “(iv) the provision to an individual in  
22 relation to individual health insurance cov-  
23 erage of management, operations, and in-  
24 vestment activities of a health insurance  
25 issuer; and

1           “(v) the provision to an individual in  
2           relation to individual health insurance cov-  
3           erage of loss control and claims adminis-  
4           tration for a health insurance issuer with  
5           respect to liability for which the issuer pro-  
6           vides insurance.

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

14          “(8) STATE.—The term ‘State’ means only the  
15          50 States and the District of Columbia.

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

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

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

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

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

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

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

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

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

1           “(I) Attempting to settle or settling claims  
2           on the basis of an application that was materi-  
3           ally altered without notice to, or knowledge or  
4           consent of, the insured.

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

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

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

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

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

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

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

6           “(iv) Premiums paid on an insurance  
7 policy or reinsurance contract.

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

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

14           “(vii) The financial condition of an in-  
15 surer or reinsurer.

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

21           “(ix) The issuance of written evidence  
22 of insurance.

23           “(x) The reinstatement of an insur-  
24 ance policy.

1           “(B) Solicitation or acceptance of new or  
2           renewal insurance risks on behalf of an insurer  
3           reinsurer or other person engaged in the busi-  
4           ness of insurance by a person who knows or  
5           should know that the insurer or other person  
6           responsible for the risk is insolvent at the time  
7           of the transaction.

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

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

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

17          “(a) IN GENERAL.—The covered laws of the primary  
18          State shall apply to individual health insurance coverage  
19          offered by a health insurance issuer in the primary State  
20          and in any secondary State, but only if the coverage and  
21          issuer comply with the conditions of this section with re-  
22          spect to the offering of coverage in any secondary State.

23          “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
24          ONDARY STATE.—Except as provided in this section, a  
25          health insurance issuer with respect to its offer, sale, rat-

1 ing (including medical underwriting), renewal, and  
2 issuance of individual health insurance coverage in any  
3 secondary State is exempt from any covered laws of the  
4 secondary State (and any rules, regulations, agreements,  
5 or orders sought or issued by such State under or related  
6 to such covered laws) to the extent that such laws would—

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

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

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

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

1           “(i) the State insurance commissioner  
2           of the primary State has not done an ex-  
3           amination within the period recommended  
4           by the National Association of Insurance  
5           Commissioners; and

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

12          “(D) to comply with a lawful order  
13          issued—

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

19                 “(ii) in a voluntary dissolution pro-  
20                 ceeding;

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

1           “(F) to participate, on a nondiscriminatory  
2 basis, in any insurance insolvency guaranty as-  
3 sociation or similar association to which a  
4 health insurance issuer in the State is required  
5 to belong;

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

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

15           “(I) to comply with the applicable require-  
16 ments for independent review under section  
17 2798 with respect to coverage offered in the  
18 State;

19           “(2) require any individual health insurance  
20 coverage issued by the issuer to be countersigned by  
21 an insurance agent or broker residing in that Sec-  
22 ondary State; or

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

1           “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
2 health insurance issuer shall provide the following notice,  
3 in 12-point bold type, in any insurance coverage offered  
4 in a secondary State under this part by such a health in-  
5 surance issuer and at renewal of the policy, with the 5  
6 blank spaces therein being appropriately filled with the  
7 name of the health insurance issuer, the name of primary  
8 State, the name of the secondary State, the name of the  
9 secondary State, and the name of the secondary State, re-  
10 spectively, for the coverage concerned:

11 This policy is issued by \_\_\_\_\_ and is governed by  
12 the laws and regulations of the State of \_\_\_\_\_, and  
13 it has met all the laws of that State as determined by  
14 that State’s Department of Insurance. This policy may be  
15 less expensive than others because it is not subject to all  
16 of the insurance laws and regulations of the State of  
17 \_\_\_\_\_, including coverage of some services or bene-  
18 fits mandated by the law of the State of \_\_\_\_\_. Ad-  
19 ditionally, this policy is not subject to all of the consumer  
20 protection laws or restrictions on rate changes of the State  
21 of \_\_\_\_\_. As with all insurance products, before pur-  
22 chasing this policy, you should carefully review the policy  
23 and determine what health care services the policy covers  
24 and what benefits it provides, including any exclusions,  
25 limitations, or conditions for such services or benefits.”.

1       “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
2 AND PREMIUM INCREASES.—

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

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

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

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

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

1           “(B) from raising premium rates for all  
2 policy holders within a class based on claims ex-  
3 perience;

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

9                   “(i) are disclosed to the consumer in  
10 the insurance contract;

11                   “(ii) are based on specific wellness ac-  
12 tivities that are not applicable to all indi-  
13 viduals; and

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

16           “(D) from reinstating lapsed coverage; or

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

21           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
22 STATE.—A health insurance issuer may not offer for sale  
23 individual health insurance coverage in a secondary State  
24 unless that coverage is currently offered for sale in the  
25 primary State.

1       “(f) LICENSING OF AGENTS OR BROKERS FOR  
2 HEALTH INSURANCE ISSUERS.—Any State may require  
3 that a person acting, or offering to act, as an agent or  
4 broker for a health insurance issuer with respect to the  
5 offering of individual health insurance coverage obtain a  
6 license from that State, with commissions or other com-  
7 pensation subject to the provisions of the laws of that  
8 State, except that a State may not impose any qualifica-  
9 tion or requirement which discriminates against a non-  
10 resident agent or broker.

11       “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
12 SURANCE COMMISSIONER.—Each health insurance issuer  
13 issuing individual health insurance coverage in both pri-  
14 mary and secondary States shall submit—

15               “(1) to the insurance commissioner of each  
16 State in which it intends to offer such coverage, be-  
17 fore it may offer individual health insurance cov-  
18 erage in such State—

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

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

1           “(C) written notice from the issuer of the  
2           issuer’s compliance with all the laws of the pri-  
3           mary State; and

4           “(2) to the insurance commissioner of each sec-  
5           ondary State in which it offers individual health in-  
6           surance coverage, a copy of the issuer’s quarterly fi-  
7           nancial statement submitted to the primary State,  
8           which statement shall be certified by an independent  
9           public accountant and contain a statement of opin-  
10          ion on loss and loss adjustment expense reserves  
11          made by—

12                   “(A) a member of the American Academy  
13                   of Actuaries; or

14                   “(B) a qualified loss reserve specialist.

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

18                   “(1) the solicitation or sale of individual health  
19                   insurance coverage by a health insurance issuer to  
20                   any person or group who is not eligible for such in-  
21                   surance; or

22                   “(2) the solicitation or sale of individual health  
23                   insurance coverage that violates the requirements of  
24                   the law of a secondary State which are described in

1 subparagraphs (A) through (H) of section  
2 2796(b)(1).

3 “(i) POWER OF SECONDARY STATES TO TAKE AD-  
4 MINISTRATIVE ACTION.—Nothing in this section shall be  
5 construed to affect the authority of any State to enjoin  
6 conduct in violation of that State’s laws described in sec-  
7 tion 2796(b)(1).

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

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

16 “(2) COURTS OF COMPETENT JURISDICTION.—

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

21 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this  
22 section shall affect the authority of any State to bring ac-  
23 tion in any Federal or State court.

24 “(l) GENERALLY APPLICABLE LAWS.—Nothing in  
25 this section shall be construed to affect the applicability

1 of State laws generally applicable to persons or corpora-  
2 tions.

3 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO  
4 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a  
5 health insurance issuer is offering coverage in a primary  
6 State that does not accommodate residents of secondary  
7 States or does not provide a working mechanism for resi-  
8 dents of a secondary State, and the issuer is offering cov-  
9 erage under this part in such secondary State which has  
10 not adopted a qualified high risk pool as its acceptable  
11 alternative mechanism (as defined in section 2744(c)(2)),  
12 the issuer shall, with respect to any individual health in-  
13 surance coverage offered in a secondary State under this  
14 part, comply with the guaranteed availability requirements  
15 for eligible individuals in section 2741.

16 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
17 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
18 **STATES.**

19 “A health insurance issuer may not offer, sell, or  
20 issue individual health insurance coverage in a secondary  
21 State if the State insurance commissioner does not use  
22 a risk-based capital formula for the determination of cap-  
23 ital and surplus requirements for all health insurance  
24 issuers.

1 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
2 **DURES.**

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

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

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

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

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

8           “(A) each independent medical reviewer  
9 meets the qualifications described in paragraphs  
10 (2) and (3);

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

16           “(C) compensation provided by the issuer  
17 to each reviewer is consistent with paragraph  
18 (6).

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

23           “(A) is appropriately credentialed or li-  
24 censed in 1 or more States to deliver health  
25 care services; and

1           “(B) typically treats the condition, makes  
2 the diagnosis, or provides the type of treatment  
3 under review.

4           “(3) INDEPENDENCE.—

5           “(A) IN GENERAL.—Subject to subpara-  
6 graph (B), each independent medical reviewer  
7 in a case shall—

8                   “(i) not be a related party (as defined  
9 in paragraph (7));

10                   “(ii) not have a material familial, fi-  
11 nancial, or professional relationship with  
12 such a party; and

13                   “(iii) not otherwise have a conflict of  
14 interest with such a party (as determined  
15 under regulations).

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

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

22                           “(I) a non-affiliated individual is  
23 not reasonably available;

1                   “(II) the affiliated individual is  
2 not involved in the provision of items  
3 or services in the case under review;

4                   “(III) the fact of such an affili-  
5 ation is disclosed to the issuer and the  
6 enrollee (or authorized representative)  
7 and neither party objects; and

8                   “(IV) the affiliated individual is  
9 not an employee of the issuer and  
10 does not provide services exclusively or  
11 primarily to or on behalf of the issuer;

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

20                   “(iii) prohibit receipt of compensation  
21 by an independent medical reviewer from  
22 an entity if the compensation is provided  
23 consistent with paragraph (6).

24                   “(4) PRACTICING HEALTH CARE PROFESSIONAL  
25 IN SAME FIELD.—

1           “(A) IN GENERAL.—In a case involving  
2 treatment, or the provision of items or serv-  
3 ices—

4           “(i) by a physician, a reviewer shall be  
5 a practicing physician (allopathic or osteo-  
6 pathic) of the same or similar specialty, as  
7 a physician who, acting within the appro-  
8 priate scope of practice within the State in  
9 which the service is provided or rendered,  
10 typically treats the condition, makes the  
11 diagnosis, or provides the type of treat-  
12 ment under review; or

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

1           “(B) PRACTICING DEFINED.—For pur-  
2           poses of this paragraph, the term ‘practicing’  
3           means, with respect to an individual who is a  
4           physician or other health care professional, that  
5           the individual provides health care services to  
6           individual patients on average at least 2 days  
7           per week.

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

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

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

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

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

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

24                 “(B) The enrollee (or authorized represent-  
25                 ative).

1           “(C) The health care professional that pro-  
2           vides the items or services involved in the de-  
3           nial.

4           “(D) The institution at which the items or  
5           services (or treatment) involved in the denial  
6           are provided.

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

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

13           “(8) DEFINITIONS.—For purposes of this sub-  
14           section:

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

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

1 **“SEC. 2799. ENFORCEMENT.**

2 “(a) IN GENERAL.—Subject to subsection (b), with  
3 respect to specific individual health insurance coverage the  
4 primary State for such coverage has sole jurisdiction to  
5 enforce the primary State’s covered laws in the primary  
6 State and any secondary State.

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

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

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

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

25 (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).

23           (d) SEVERABILITY.—If any provision of the section  
24           or the application of such provision to any person or cir-  
25           cumstance is held to be unconstitutional, the remainder

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

3 **TITLE IV—HELP EFFICIENT, AC-**  
4 **CESSIBLE, LOW-COST, TIMELY**  
5 **HEALTHCARE (HEALTH) ACT**  
6 **OF 2007**

7 **SEC. 401. SHORT TITLE.**

8 This title may be cited as the “Help Efficient, Acces-  
9 sible, Low-cost, Timely Healthcare (HEALTH) Act of  
10 2007”.

11 **SEC. 402. FINDINGS AND PURPOSE.**

12 (a) FINDINGS.—

13 (1) EFFECT ON HEALTH CARE ACCESS AND  
14 COSTS.—Congress finds that our current civil justice  
15 system is adversely affecting patient access to health  
16 care services, better patient care, and cost-efficient  
17 health care, in that the health care liability system  
18 is a costly and ineffective mechanism for resolving  
19 claims of health care liability and compensating in-  
20 jured patients, and is a deterrent to the sharing of  
21 information among health care professionals which  
22 impedes efforts to improve patient safety and quality  
23 of care.

24 (2) EFFECT ON INTERSTATE COMMERCE.—

25 Congress finds that the health care and insurance

1 industries are industries affecting interstate com-  
2 merce and the health care liability litigation systems  
3 existing throughout the United States are activities  
4 that affect interstate commerce by contributing to  
5 the high costs of health care and premiums for  
6 health care liability insurance purchased by health  
7 care system providers.

8 (3) EFFECT ON FEDERAL SPENDING.—Con-  
9 gress finds that the health care liability litigation  
10 systems existing throughout the United States have  
11 a significant effect on the amount, distribution, and  
12 use of Federal funds because of—

13 (A) the large number of individuals who  
14 receive health care benefits under programs op-  
15 erated or financed by the Federal Government;

16 (B) the large number of individuals who  
17 benefit because of the exclusion from Federal  
18 taxes of the amounts spent to provide them  
19 with health insurance benefits; and

20 (C) the large number of health care pro-  
21 viders who provide items or services for which  
22 the Federal Government makes payments.

23 (b) PURPOSE.—It is the purpose of this title to imple-  
24 ment reasonable, comprehensive, and effective health care  
25 liability reforms designed to—

1           (1) improve the availability of health care serv-  
2           ices in cases in which health care liability actions  
3           have been shown to be a factor in the decreased  
4           availability of services;

5           (2) reduce the incidence of “defensive medi-  
6           cine” and lower the cost of health care liability in-  
7           surance, all of which contribute to the escalation of  
8           health care costs;

9           (3) ensure that persons with meritorious health  
10          care injury claims receive fair and adequate com-  
11          pensation, including reasonable noneconomic dam-  
12          ages;

13          (4) improve the fairness and cost-effectiveness  
14          of our current health care liability system to resolve  
15          disputes over, and provide compensation for, health  
16          care liability by reducing uncertainty in the amount  
17          of compensation provided to injured individuals; and

18          (5) provide an increased sharing of information  
19          in the health care system which will reduce unin-  
20          tended injury and improve patient care.

21 **SEC. 403. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

22          The time for the commencement of a health care law-  
23          suit shall be 3 years after the date of manifestation of  
24          injury or 1 year after the claimant discovers, or through  
25          the use of reasonable diligence should have discovered, the

1 injury, whichever occurs first. In no event shall the time  
2 for commencement of a health care lawsuit exceed 3 years  
3 after the date of manifestation of injury unless tolled for  
4 any of the following—

5 (1) upon proof of fraud;

6 (2) intentional concealment; or

7 (3) the presence of a foreign body, which has no  
8 therapeutic or diagnostic purpose or effect, in the  
9 person of the injured person. Actions by a minor  
10 shall be commenced within 3 years from the date of  
11 the alleged manifestation of injury except that ac-  
12 tions by a minor under the full age of 6 years shall  
13 be commenced within 3 years of manifestation of in-  
14 jury or prior to the minor's 8th birthday, whichever  
15 provides a longer period. Such time limitation shall  
16 be tolled for minors for any period during which a  
17 parent or guardian and a health care provider or  
18 health care organization have committed fraud or  
19 collusion in the failure to bring an action on behalf  
20 of the injured minor

21 **SEC. 404. COMPENSATING PATIENT INJURY.**

22 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL  
23 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any  
24 health care lawsuit, nothing in this title shall limit a claim-

1 ant's recovery of the full amount of the available economic  
2 damages, notwithstanding the limitation in subsection (b).

3 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any  
4 health care lawsuit, the amount of noneconomic damages,  
5 if available, may be as much as \$250,000, regardless of  
6 the number of parties against whom the action is brought  
7 or the number of separate claims or actions brought with  
8 respect to the same injury.

9 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC  
10 DAMAGES.—For purposes of applying the limitation in  
11 subsection (b), future noneconomic damages shall not be  
12 discounted to present value. The jury shall not be in-  
13 formed about the maximum award for noneconomic dam-  
14 ages. An award for noneconomic damages in excess of  
15 \$250,000 shall be reduced either before the entry of judg-  
16 ment, or by amendment of the judgment after entry of  
17 judgment, and such reduction shall be made before ac-  
18 counting for any other reduction in damages required by  
19 law. If separate awards are rendered for past and future  
20 noneconomic damages and the combined awards exceed  
21 \$250,000, the future noneconomic damages shall be re-  
22 duced first.

23 (d) FAIR SHARE RULE.—In any health care lawsuit,  
24 each party shall be liable for that party's several share  
25 of any damages only and not for the share of any other

1 person. Each party shall be liable only for the amount of  
2 damages allocated to such party in direct proportion to  
3 such party's percentage of responsibility. Whenever a  
4 judgment of liability is rendered as to any party, a sepa-  
5 rate judgment shall be rendered against each such party  
6 for the amount allocated to such party. For purposes of  
7 this section, the trier of fact shall determine the propor-  
8 tion of responsibility of each party for the claimant's  
9 harm.

10 **SEC. 405. MAXIMIZING PATIENT RECOVERY.**

11 (a) COURT SUPERVISION OF SHARE OF DAMAGES  
12 ACTUALLY PAID TO CLAIMANTS.—In any health care law-  
13 suit, the court shall supervise the arrangements for pay-  
14 ment of damages to protect against conflicts of interest  
15 that may have the effect of reducing the amount of dam-  
16 ages awarded that are actually paid to claimants. In par-  
17 ticular, in any health care lawsuit in which the attorney  
18 for a party claims a financial stake in the outcome by vir-  
19 tue of a contingent fee, the court shall have the power  
20 to restrict the payment of a claimant's damage recovery  
21 to such attorney, and to redirect such damages to the  
22 claimant based upon the interests of justice and principles  
23 of equity. In no event shall the total of all contingent fees  
24 for representing all claimants in a health care lawsuit ex-  
25 ceed the following limits:

1           (1) 40 percent of the first \$50,000 recovered by  
2           the claimant(s).

3           (2) 33 $\frac{1}{3}$  percent of the next \$50,000 recovered  
4           by the claimant(s).

5           (3) 25 percent of the next \$500,000 recovered  
6           by the claimant(s).

7           (4) 15 percent of any amount by which the re-  
8           covery by the claimant(s) is in excess of \$600,000.

9           (b) APPLICABILITY.—The limitations in this section  
10          shall apply whether the recovery is by judgment, settle-  
11          ment, mediation, arbitration, or any other form of alter-  
12          native dispute resolution. In a health care lawsuit involv-  
13          ing a minor or incompetent person, a court retains the  
14          authority to authorize or approve a fee that is less than  
15          the maximum permitted under this section. The require-  
16          ment for court supervision in the first two sentences of  
17          subsection (a) applies only in civil actions.

18          **SEC. 406. ADDITIONAL HEALTH BENEFITS.**

19          In any health care lawsuit involving injury or wrong-  
20          ful death, any party may introduce evidence of collateral  
21          source benefits. If a party elects to introduce such evi-  
22          dence, any opposing party may introduce evidence of any  
23          amount paid or contributed or reasonably likely to be paid  
24          or contributed in the future by or on behalf of the oppos-  
25          ing party to secure the right to such collateral source bene-

1 fits. No provider of collateral source benefits shall recover  
2 any amount against the claimant or receive any lien or  
3 credit against the claimant's recovery or be equitably or  
4 legally subrogated to the right of the claimant in a health  
5 care lawsuit involving injury or wrongful death. This sec-  
6 tion shall apply to any health care lawsuit that is settled  
7 as well as a health care lawsuit that is resolved by a fact  
8 finder. This section shall not apply to section 1862(b) (42  
9 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.  
10 1396a(a)(25)) of the Social Security Act.

11 **SEC. 407. PUNITIVE DAMAGES.**

12 (a) IN GENERAL.—Punitive damages may, if other-  
13 wise permitted by applicable State or Federal law, be  
14 awarded against any person in a health care lawsuit only  
15 if it is proven by clear and convincing evidence that such  
16 person acted with malicious intent to injure the claimant,  
17 or that such person deliberately failed to avoid unneces-  
18 sary injury that such person knew the claimant was sub-  
19 stantially certain to suffer. In any health care lawsuit  
20 where no judgment for compensatory damages is rendered  
21 against such person, no punitive damages may be awarded  
22 with respect to the claim in such lawsuit. No demand for  
23 punitive damages shall be included in a health care lawsuit  
24 as initially filed. A court may allow a claimant to file an  
25 amended pleading for punitive damages only upon a mo-

1 tion by the claimant and after a finding by the court, upon  
2 review of supporting and opposing affidavits or after a  
3 hearing, after weighing the evidence, that the claimant has  
4 established by a substantial probability that the claimant  
5 will prevail on the claim for punitive damages. At the re-  
6 quest of any party in a health care lawsuit, the trier of  
7 fact shall consider in a separate proceeding—

8 (1) whether punitive damages are to be award-  
9 ed and the amount of such award; and

10 (2) the amount of punitive damages following a  
11 determination of punitive liability.

12 If a separate proceeding is requested, evidence relevant  
13 only to the claim for punitive damages, as determined by  
14 applicable State law, shall be inadmissible in any pro-  
15 ceeding to determine whether compensatory damages are  
16 to be awarded.

17 (b) DETERMINING AMOUNT OF PUNITIVE DAM-  
18 AGES.—

19 (1) FACTORS CONSIDERED.—In determining  
20 the amount of punitive damages, if awarded, in a  
21 health care lawsuit, the trier of fact shall consider  
22 only the following—

23 (A) the severity of the harm caused by the  
24 conduct of such party;

1 (B) the duration of the conduct or any  
2 concealment of it by such party;

3 (C) the profitability of the conduct to such  
4 party;

5 (D) the number of products sold or med-  
6 ical procedures rendered for compensation, as  
7 the case may be, by such party, of the kind  
8 causing the harm complained of by the claim-  
9 ant;

10 (E) any criminal penalties imposed on such  
11 party, as a result of the conduct complained of  
12 by the claimant; and

13 (F) the amount of any civil fines assessed  
14 against such party as a result of the conduct  
15 complained of by the claimant.

16 (2) MAXIMUM AWARD.—The amount of punitive  
17 damages, if awarded, in a health care lawsuit may  
18 be as much as \$250,000 or as much as two times  
19 the amount of economic damages awarded, which-  
20 ever is greater. The jury shall not be informed of  
21 this limitation.

22 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT  
23 COMPLY WITH FDA STANDARDS.—

24 (1) IN GENERAL.—

1           (A) No punitive damages may be awarded  
2 against the manufacturer or distributor of a  
3 medical product, or a supplier of any compo-  
4 nent or raw material of such medical product,  
5 based on a claim that such product caused the  
6 claimant's harm where—

7           (i)(I) such medical product was sub-  
8 ject to premarket approval, clearance, or li-  
9 censure by the Food and Drug Administra-  
10 tion with respect to the safety of the for-  
11 mulation or performance of the aspect of  
12 such medical product which caused the  
13 claimant's harm or the adequacy of the  
14 packaging or labeling of such medical  
15 product; and

16           (II) such medical product was so ap-  
17 proved, cleared, or licensed; or

18           (ii) such medical product is generally  
19 recognized among qualified experts as safe  
20 and effective pursuant to conditions estab-  
21 lished by the Food and Drug Administra-  
22 tion and applicable Food and Drug Admin-  
23 istration regulations, including without  
24 limitation those related to packaging and  
25 labeling, unless the Food and Drug Admin-

1           istration has determined that such medical  
2           product was not manufactured or distrib-  
3           uted in substantial compliance with appli-  
4           cable Food and Drug Administration stat-  
5           utes and regulations.

6           (B) RULE OF CONSTRUCTION.—Subpara-  
7           graph (A) may not be construed as establishing  
8           the obligation of the Food and Drug Adminis-  
9           tration to demonstrate affirmatively that a  
10          manufacturer, distributor, or supplier referred  
11          to in such subparagraph meets any of the con-  
12          ditions described in such subparagraph.

13          (2) LIABILITY OF HEALTH CARE PROVIDERS.—  
14          A health care provider who prescribes, or who dis-  
15          penses pursuant to a prescription, a medical product  
16          approved, licensed, or cleared by the Food and Drug  
17          Administration shall not be named as a party to a  
18          product liability lawsuit involving such product and  
19          shall not be liable to a claimant in a class action  
20          lawsuit against the manufacturer, distributor, or  
21          seller of such product. Nothing in this paragraph  
22          prevents a court from consolidating cases involving  
23          health care providers and cases involving products li-  
24          ability claims against the manufacturer, distributor,  
25          or product seller of such medical product.

1           (3) PACKAGING.—In a health care lawsuit for  
2           harm which is alleged to relate to the adequacy of  
3           the packaging or labeling of a drug which is required  
4           to have tamper-resistant packaging under regula-  
5           tions of the Secretary of Health and Human Serv-  
6           ices (including labeling regulations related to such  
7           packaging), the manufacturer or product seller of  
8           the drug shall not be held liable for punitive dam-  
9           ages unless such packaging or labeling is found by  
10          the trier of fact by clear and convincing evidence to  
11          be substantially out of compliance with such regula-  
12          tions.

13          (4) EXCEPTION.—Paragraph (1) shall not  
14          apply in any health care lawsuit in which—

15                (A) a person, before or after premarket ap-  
16                proval, clearance, or licensure of such medical  
17                product, knowingly misrepresented to or with-  
18                held from the Food and Drug Administration  
19                information that is required to be submitted  
20                under the Federal Food, Drug, and Cosmetic  
21                Act (21 U.S.C. 301 et seq.) or section 351 of  
22                the Public Health Service Act (42 U.S.C. 262)  
23                that is material and is causally related to the  
24                harm which the claimant allegedly suffered; or

1           (B) a person made an illegal payment to  
2           an official of the Food and Drug Administra-  
3           tion for the purpose of either securing or main-  
4           taining approval, clearance, or licensure of such  
5           medical product.

6 **SEC. 408. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**  
7                   **AGES TO CLAIMANTS IN HEALTH CARE LAW-**  
8                   **SUITS.**

9           (a) IN GENERAL.—In any health care lawsuit, if an  
10          award of future damages, without reduction to present  
11          value, equaling or exceeding \$50,000 is made against a  
12          party with sufficient insurance or other assets to fund a  
13          periodic payment of such a judgment, the court shall, at  
14          the request of any party, enter a judgment ordering that  
15          the future damages be paid by periodic payments. In any  
16          health care lawsuit, the court may be guided by the Uni-  
17          form Periodic Payment of Judgments Act promulgated by  
18          the National Conference of Commissioners on Uniform  
19          State Laws.

20          (b) APPLICABILITY.—This section applies to all ac-  
21          tions which have not been first set for trial or retrial be-  
22          fore the effective date of this title.

23 **SEC. 409. DEFINITIONS.**

24          In this title:

1           (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
2           TEM; ADR.—The term “alternative dispute resolution  
3           system” or “ADR” means a system that provides  
4           for the resolution of health care lawsuits in a man-  
5           ner other than through a civil action brought in a  
6           State or Federal court.

7           (2) CLAIMANT.—The term “claimant” means  
8           any person who brings a health care lawsuit, includ-  
9           ing a person who asserts or claims a right to legal  
10          or equitable contribution, indemnity or subrogation,  
11          arising out of a health care liability claim or action,  
12          and any person on whose behalf such a claim is as-  
13          serted or such an action is brought, whether de-  
14          ceased, incompetent, or a minor.

15          (3) COLLATERAL SOURCE BENEFITS.—The  
16          term “collateral source benefits” means any amount  
17          paid or reasonably likely to be paid in the future to  
18          or on behalf of the claimant, or any service, product  
19          or other benefit provided or reasonably likely to be  
20          provided in the future to or on behalf of the claim-  
21          ant, as a result of the injury or wrongful death, pur-  
22          suant to—

23                   (A) any State or Federal health, sickness,  
24                   income-disability, accident, or workers’ com-  
25                   pensation law;

1           (B) any health, sickness, income-disability,  
2           or accident insurance that provides health bene-  
3           fits or income-disability coverage;

4           (C) any contract or agreement of any  
5           group, organization, partnership, or corporation  
6           to provide, pay for, or reimburse the cost of  
7           medical, hospital, dental, or income disability  
8           benefits; and

9           (D) any other publicly or privately funded  
10          program.

11          (4) COMPENSATORY DAMAGES.—The term  
12          “compensatory damages” means objectively  
13          verifiable monetary losses incurred as a result of the  
14          provision of, use of, or payment for (or failure to  
15          provide, use, or pay for) health care services or med-  
16          ical products, such as past and future medical ex-  
17          penses, loss of past and future earnings, cost of ob-  
18          taining domestic services, loss of employment, and  
19          loss of business or employment opportunities, dam-  
20          ages for physical and emotional pain, suffering, in-  
21          convenience, physical impairment, mental anguish,  
22          disfigurement, loss of enjoyment of life, loss of soci-  
23          ety and companionship, loss of consortium (other  
24          than loss of domestic service), hedonic damages, in-  
25          jury to reputation, and all other nonpecuniary losses

1 of any kind or nature. The term “compensatory  
2 damages” includes economic damages and non-  
3 economic damages, as such terms are defined in this  
4 section.

5 (5) CONTINGENT FEE.—The term “contingent  
6 fee” includes all compensation to any person or per-  
7 sons which is payable only if a recovery is effected  
8 on behalf of one or more claimants.

9 (6) ECONOMIC DAMAGES.—The term “economic  
10 damages” means objectively verifiable monetary  
11 losses incurred as a result of the provision of, use  
12 of, or payment for (or failure to provide, use, or pay  
13 for) health care services or medical products, such as  
14 past and future medical expenses, loss of past and  
15 future earnings, cost of obtaining domestic services,  
16 loss of employment, and loss of business or employ-  
17 ment opportunities.

18 (7) HEALTH CARE LAWSUIT.—The term  
19 “health care lawsuit” means any health care liability  
20 claim concerning the provision of health care goods  
21 or services or any medical product affecting inter-  
22 state commerce, or any health care liability action  
23 concerning the provision of health care goods or  
24 services or any medical product affecting interstate  
25 commerce, brought in a State or Federal court or

1       pursuant to an alternative dispute resolution system,  
2       against a health care provider, a health care organi-  
3       zation, or the manufacturer, distributor, supplier,  
4       marketer, promoter, or seller of a medical product,  
5       regardless of the theory of liability on which the  
6       claim is based, or the number of claimants, plain-  
7       tiffs, defendants, or other parties, or the number of  
8       claims or causes of action, in which the claimant al-  
9       leges a health care liability claim. Such term does  
10      not include a claim or action which is based on  
11      criminal liability; which seeks civil fines or penalties  
12      paid to Federal, State, or local government; or which  
13      is grounded in antitrust.

14           (8) HEALTH CARE LIABILITY ACTION.—The  
15      term “health care liability action” means a civil ac-  
16      tion brought in a State or Federal Court or pursu-  
17      ant to an alternative dispute resolution system,  
18      against a health care provider, a health care organi-  
19      zation, or the manufacturer, distributor, supplier,  
20      marketer, promoter, or seller of a medical product,  
21      regardless of the theory of liability on which the  
22      claim is based, or the number of plaintiffs, defend-  
23      ants, or other parties, or the number of causes of ac-  
24      tion, in which the claimant alleges a health care li-  
25      ability claim.

1           (9) HEALTH CARE LIABILITY CLAIM.—The  
2 term “health care liability claim” means a demand  
3 by any person, whether or not pursuant to ADR,  
4 against a health care provider, health care organiza-  
5 tion, or the manufacturer, distributor, supplier, mar-  
6 keter, promoter, or seller of a medical product, in-  
7 cluding, but not limited to, third-party claims, cross-  
8 claims, counter-claims, or contribution claims, which  
9 are based upon the provision of, use of, or payment  
10 for (or the failure to provide, use, or pay for) health  
11 care services or medical products, regardless of the  
12 theory of liability on which the claim is based, or the  
13 number of plaintiffs, defendants, or other parties, or  
14 the number of causes of action.

15           (10) HEALTH CARE ORGANIZATION.—The term  
16 “health care organization” means any person or en-  
17 tity which is obligated to provide or pay for health  
18 benefits under any health plan, including any person  
19 or entity acting under a contract or arrangement  
20 with a health care organization to provide or admin-  
21 ister any health benefit.

22           (11) HEALTH CARE PROVIDER.—The term  
23 “health care provider” means any person or entity  
24 required by State or Federal laws or regulations to  
25 be licensed, registered, or certified to provide health

1 care services, and being either so licensed, reg-  
2 istered, or certified, or exempted from such require-  
3 ment by other statute or regulation.

4 (12) HEALTH CARE GOODS OR SERVICES.—The  
5 term “health care goods or services” means any  
6 goods or services provided by a health care organiza-  
7 tion, provider, or by any individual working under  
8 the supervision of a health care provider, that relates  
9 to the diagnosis, prevention, or treatment of any  
10 human disease or impairment, or the assessment or  
11 care of the health of human beings.

12 (13) MALICIOUS INTENT TO INJURE.—The  
13 term “malicious intent to injure” means inten-  
14 tionally causing or attempting to cause physical in-  
15 jury other than providing health care goods or serv-  
16 ices.

17 (14) MEDICAL PRODUCT.—The term “medical  
18 product” means a drug, device, or biological product  
19 intended for humans, and the terms “drug”, “de-  
20 vice”, and “biological product” have the meanings  
21 given such terms in sections 201(g)(1) and 201(h)  
22 of the Federal Food, Drug and Cosmetic Act (21  
23 U.S.C. 321) and section 351(a) of the Public Health  
24 Service Act (42 U.S.C. 262(a)), respectively, includ-

1 ing any component or raw material used therein, but  
2 excluding health care services.

3 (15) NONECONOMIC DAMAGES.—The term  
4 “noneconomic damages” means damages for phys-  
5 ical and emotional pain, suffering, inconvenience,  
6 physical impairment, mental anguish, disfigurement,  
7 loss of enjoyment of life, loss of society and compan-  
8 ionship, loss of consortium (other than loss of do-  
9 mestic service), hedonic damages, injury to reputa-  
10 tion, and all other nonpecuniary losses of any kind  
11 or nature.

12 (16) PUNITIVE DAMAGES.—The term “punitive  
13 damages” means damages awarded, for the purpose  
14 of punishment or deterrence, and not solely for com-  
15 pensatory purposes, against a health care provider,  
16 health care organization, or a manufacturer, dis-  
17 tributor, or supplier of a medical product. Punitive  
18 damages are neither economic nor noneconomic  
19 damages.

20 (17) RECOVERY.—The term “recovery” means  
21 the net sum recovered after deducting any disburse-  
22 ments or costs incurred in connection with prosecu-  
23 tion or settlement of the claim, including all costs  
24 paid or advanced by any person. Costs of health care  
25 incurred by the plaintiff and the attorneys’ office

1 overhead costs or charges for legal services are not  
2 deductible disbursements or costs for such purpose.

3 (18) STATE.—The term “State” means each of  
4 the several States, the District of Columbia, the  
5 Commonwealth of Puerto Rico, the Virgin Islands,  
6 Guam, American Samoa, the Northern Mariana Is-  
7 lands, the Trust Territory of the Pacific Islands, and  
8 any other territory or possession of the United  
9 States, or any political subdivision thereof.

10 **SEC. 410. EFFECT ON OTHER LAWS.**

11 (a) VACCINE INJURY.—

12 (1) To the extent that title XXI of the Public  
13 Health Service Act establishes a Federal rule of law  
14 applicable to a civil action brought for a vaccine-re-  
15 lated injury or death—

16 (A) this title does not affect the application  
17 of the rule of law to such an action; and

18 (B) any rule of law prescribed by this title  
19 in conflict with a rule of law of such title XXI  
20 shall not apply to such action.

21 (2) If there is an aspect of a civil action  
22 brought for a vaccine-related injury or death to  
23 which a Federal rule of law under title XXI of the  
24 Public Health Service Act does not apply, then this  
25 title or otherwise applicable law (as determined

1 under this title) will apply to such aspect of such ac-  
2 tion.

3 (b) OTHER FEDERAL LAW.—Except as provided in  
4 this section, nothing in this title shall be deemed to affect  
5 any defense available to a defendant in a health care law-  
6 suit or action under any other provision of Federal law.

7 **SEC. 411. STATE FLEXIBILITY AND PROTECTION OF**  
8 **STATES' RIGHTS.**

9 (a) HEALTH CARE LAWSUITS.—The provisions gov-  
10 erning health care lawsuits set forth in this title preempt,  
11 subject to subsections (b) and (c), State law to the extent  
12 that State law prevents the application of any provisions  
13 of law established by or under this title. The provisions  
14 governing health care lawsuits set forth in this title super-  
15 sede chapter 171 of title 28, United States Code, to the  
16 extent that such chapter—

17 (1) provides for a greater amount of damages  
18 or contingent fees, a longer period in which a health  
19 care lawsuit may be commenced, or a reduced appli-  
20 cability or scope of periodic payment of future dam-  
21 ages, than provided in this title; or

22 (2) prohibits the introduction of evidence re-  
23 garding collateral source benefits, or mandates or  
24 permits subrogation or a lien on collateral source  
25 benefits.

1 (b) PROTECTION OF STATES' RIGHTS AND OTHER  
2 LAWS.—(1) Any issue that is not governed by any provi-  
3 sion of law established by or under this title (including  
4 State standards of gross negligence) shall be governed by  
5 otherwise applicable State or Federal law.

6 (2) This title shall not preempt or supersede any  
7 State or Federal law that imposes greater procedural or  
8 substantive protections for health care providers and  
9 health care organizations from liability, loss, or damages  
10 than those provided by this title or create a cause of ac-  
11 tion.

12 (c) STATE FLEXIBILITY.—No provision of this title  
13 shall be construed to preempt—

14 (1) any State law (whether effective before, on,  
15 or after the date of the enactment of this title) that  
16 specifies a particular monetary amount of compen-  
17 satory or punitive damages (or the total amount of  
18 damages) that may be awarded in a health care law-  
19 suit, regardless of whether such monetary amount is  
20 greater or lesser than is provided for under this title,  
21 notwithstanding section 4(a); or

22 (2) any defense available to a party in a health  
23 care lawsuit under any other provision of State or  
24 Federal law.

1 **SEC. 412. APPLICABILITY; EFFECTIVE DATE.**

2 The previous provisions of this title shall apply to any  
3 health care lawsuit brought in a Federal or State court,  
4 or subject to an alternative dispute resolution system, that  
5 is initiated on or after the date of the enactment of this  
6 title, except that any health care lawsuit arising from an  
7 injury occurring prior to the date of the enactment of this  
8 title shall be governed by the applicable statute of limita-  
9 tions provisions in effect at the time the injury occurred.

10 **SEC. 413. SENSE OF CONGRESS.**

11 It is the sense of Congress that a health insurer  
12 should be liable for damages for harm caused when it  
13 makes a decision as to what care is medically necessary  
14 and appropriate.

15 **SEC. 414. STATE GRANTS TO CREATE ADMINISTRATIVE**  
16 **HEALTH CARE TRIBUNALS.**

17 Part P of title III of the Public Health Service Act  
18 (42 U.S.C. 280g et seq.) is amended by adding at the end  
19 the following:

20 **“SEC. 399R. STATE GRANTS TO CREATE ADMINISTRATIVE**  
21 **HEALTH CARE TRIBUNALS.**

22 “(a) IN GENERAL.—The Secretary may award grants  
23 to States for the development, implementation, and eval-  
24 uation of administrative health care tribunals that comply  
25 with this section, for the resolution of disputes concerning  
26 injuries allegedly caused by health care providers.

1           “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—  
2 To be eligible to receive a grant under this section, a State  
3 shall submit to the Secretary an application at such time,  
4 in such manner, and containing such information as may  
5 be required by the Secretary. A grant shall be awarded  
6 under this section on such terms and conditions as the  
7 Secretary determines appropriate.

8           “(c) REPRESENTATION BY COUNSEL.—A State that  
9 receives a grant under this section may not preclude any  
10 party to a dispute before an administrative health care tri-  
11 bunal operated under such grant from obtaining legal rep-  
12 resentation during any review by the expert panel under  
13 subsection (d), the administrative health care tribunal  
14 under subsection (e), or a State court under subsection  
15 (f).

16           “(d) EXPERT PANEL REVIEW AND EARLY OFFER  
17 GUIDELINES.—

18                   “(1) IN GENERAL.—Prior to the submission of  
19 any dispute concerning injuries allegedly caused by  
20 health care providers to an administrative health  
21 care tribunal under this section, such allegations  
22 shall first be reviewed by an expert panel.

23                   “(2) COMPOSITION.—

24                           “(A) IN GENERAL.—The members of each  
25 expert panel under this subsection appointed by

1 the head of the State agency responsible for  
2 health. At least one-half of such members shall  
3 be medical experts (either physicians or health  
4 care professionals).

5 “(B) LICENSURE AND EXPERTISE.—Each  
6 physician or health care professional appointed  
7 to an expert panel under subparagraph (A)  
8 shall—

9 “(i) be appropriately credentialed or  
10 licensed in 1 or more States to deliver  
11 health care services; and

12 “(ii) typically treat the condition,  
13 make the diagnosis, or provide the type of  
14 treatment that is under review.

15 “(C) INDEPENDENCE.—

16 “(i) IN GENERAL.—Subject to clause  
17 (ii), each individual appointed to an expert  
18 panel under this paragraph shall—

19 “(I) not have a material familial,  
20 financial, or professional relationship  
21 with a party involved in the dispute  
22 reviewed by the panel; and

23 “(II) not otherwise have a con-  
24 flict of interest with such a party.

1           “(ii) EXCEPTION.—Nothing in clause  
2           (i) shall be construed to prohibit an indi-  
3           vidual who has staff privileges at an insti-  
4           tution where the treatment involved in the  
5           dispute was provided from serving as a  
6           member of an expert panel merely on the  
7           basis of such affiliation, if the affiliation is  
8           disclosed to the parties and neither party  
9           objects.

10           “(D) PRACTICING HEALTH CARE PROFES-  
11           SIONAL IN SAME FIELD.—

12           “(i) IN GENERAL.—In a dispute be-  
13           fore an expert panel that involves treat-  
14           ment, or the provision of items or serv-  
15           ices—

16           “(I) by a physician, the medical  
17           experts on the expert panel shall be  
18           practicing physicians (allopathic or os-  
19           teopathic) of the same or similar spe-  
20           cialty as a physician who typically  
21           treats the condition, makes the diag-  
22           nosis, or provides the type of treat-  
23           ment under review; or

24           “(II) by a health care profes-  
25           sional other than a physician, at least

1 two medical experts on the expert  
2 panel shall be practicing physicians  
3 (allopathic or osteopathic) of the same  
4 or similar specialty as the health care  
5 professional who typically treats the  
6 condition, makes the diagnosis, or  
7 provides the type of treatment under  
8 review, and, if determined appropriate  
9 by the State agency, the third medical  
10 expert shall be a practicing health  
11 care professional (other than such a  
12 physician) of such a same or similar  
13 specialty.

14 “(ii) PRACTICING DEFINED.—In this  
15 paragraph, the term ‘practicing’ means,  
16 with respect to an individual who is a phy-  
17 sician or other health care professional,  
18 that the individual provides health care  
19 services to individual patients on average  
20 at least 2 days a week.

21 “(E) PEDIATRIC EXPERTISE.—In the case  
22 of dispute relating to a child, at least 1 medical  
23 expert on the expert panel shall have expertise  
24 described in subparagraph (D)(i) in pediatrics.

1           “(3) DETERMINATION.—After a review under  
2 paragraph (1), an expert panel shall make a deter-  
3 mination as to the liability of the parties involved  
4 and compensation.

5           “(4) ACCEPTANCE.—If the parties to a dispute  
6 before an expert panel under this subsection accept  
7 the determination of the expert panel concerning li-  
8 ability and compensation, such compensation shall  
9 be paid to the claimant and the claimant shall agree  
10 to forgo any further action against the health care  
11 providers involved.

12           “(5) FAILURE TO ACCEPT.—If any party de-  
13 cides not to accept the expert panel’s determination,  
14 the matter shall be referred to an administrative  
15 health care tribunal created pursuant to this section.

16           “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

17           “(1) IN GENERAL.—Upon the failure of any  
18 party to accept the determination of an expert panel  
19 under subsection (d), the parties shall have the right  
20 to request a hearing concerning the liability or com-  
21 pensation involved by an administrative health care  
22 tribunal established by the State involved.

23           “(2) REQUIREMENTS.—In establishing an ad-  
24 ministrative health care tribunal under this section,  
25 a State shall—

1           “(A) ensure that such tribunals are pre-  
2           sided over by special judges with health care ex-  
3           pertise;

4           “(B) provide authority to such judges to  
5           make binding rulings, rendered in written deci-  
6           sions, on standards of care, causation, com-  
7           pensation, and related issues with reliance on  
8           independent expert witnesses commissioned by  
9           the tribunal;

10           “(C) establish gross negligence as the legal  
11           standard for the tribunal;

12           “(D) allow the admission into evidence of  
13           the recommendation made by the expert panel  
14           under subsection (d); and

15           “(E) provide for an appeals process to  
16           allow for review of decisions by State courts.

17           “(f) REVIEW BY STATE COURT AFTER EXHAUSTION  
18           OF ADMINISTRATIVE REMEDIES.—

19           “(1) RIGHT TO FILE.—If any party to a dispute  
20           before a health care tribunal under subsection (e) is  
21           not satisfied with the determinations of the tribunal,  
22           the party shall have the right to file their claim in  
23           a State court of competent jurisdiction.

24           “(2) FORFEIT OF AWARDS.—Any party filing  
25           an action in a State court in accordance with para-

1 graph (1) shall forfeit any compensation award  
2 made under subsection (e).

3 “(3) ADMISSIBILITY.—The determinations of  
4 the expert panel and the administrative health care  
5 tribunal pursuant to subsections (d) and (e) with re-  
6 spect to a State court proceeding under paragraph  
7 (1) shall be admissible into evidence in any such  
8 State court proceeding.

9 “(g) DEFINITION.—In this section, the term ‘health  
10 care provider’ has the meaning given such term for pur-  
11 poses of part A of title VII.

12 “(h) FUNDING.—

13 “(1) ONE-TIME INCREASE IN MEDICAID PAY-  
14 MENT.—In the case of a State awarded a grant to  
15 carry out this section, the total amount of Federal  
16 payments made to the State under section 1903(a)  
17 of the Social Security Act or section 1939(b) of such  
18 Act (in the case of fiscal year 2010 or any fiscal  
19 year thereafter) for the first fiscal year for which  
20 such grant is awarded shall be increased by an  
21 amount equal to 1 percent of of the total amount of  
22 such payments made to the State for the preceding  
23 fiscal year under such 1903(a) or 1939(b) (as appli-  
24 cable) for purposes of carrying out this section.

1 Amounts paid to a State pursuant to this subsection  
2 shall remain available until expended.

3 “(2) AUTHORIZATION OF APPROPRIATIONS.—  
4 There are authorized to be appropriated for any fis-  
5 cal year such sums as may be necessary for purposes  
6 of making payments to States pursuant to para-  
7 graph (1).”.

8 **TITLE V—TAX CREDIT FOR**  
9 **HEALTH INFORMATION TECH-**  
10 **NOLOGY**

11 **SEC. 501. PURCHASE OF QUALIFIED HEALTH CARE INFOR-**  
12 **MATION TECHNOLOGY.**

13 (a) IN GENERAL.—Section 179 of the Internal Rev-  
14 enue Code of 1986 (relating to election to expense certain  
15 depreciable assets) is amended by adding at the end the  
16 following new subsection:

17 “(e) HEALTH CARE INFORMATION TECHNOLOGY.—

18 “(1) IN GENERAL.—In the case of qualified  
19 health care information technology purchased by a  
20 medical care provider and placed in service during a  
21 taxable year—

22 “(A) subsection (b)(1) shall be applied by  
23 substituting ‘\$300,000’ for ‘\$100,000’,

24 “(B) subsection (b)(2) shall be applied by  
25 substituting ‘\$600,000’ for ‘\$400,000’, and

1           “(C) subsection (b)(5)(A) shall be applied  
2           by substituting ‘\$300,000 and \$600,000’ for  
3           ‘\$100,000 and \$400,000’.

4           “(2) DEFINITIONS.—For purposes of this sub-  
5           section—

6           “(A) QUALIFIED HEALTH CARE INFORMA-  
7           TION TECHNOLOGY.—The term ‘qualified health  
8           care information technology’ means section 179  
9           property which is used primarily for the elec-  
10          tronic creation, maintenance, and exchange of  
11          medical care information to improve the quality  
12          or efficiency of medical care.

13          “(B) MEDICAL CARE PROVIDER.—The  
14          term ‘medical care provider’ means any person  
15          engaged in the trade or business of providing  
16          medical care.

17          “(C) MEDICAL CARE.—The term ‘medical  
18          care’ has the meaning given such term by sec-  
19          tion 213(d).”.

20          (b) EFFECTIVE DATE.—The amendment made by  
21          this section shall apply to property placed in service after  
22          December 31, 2006.

1 **SEC. 502. TELECOMMUNICATIONS CREDIT FOR QUALIFIED**  
2 **MEDICAL CARE PROVIDERS.**

3 (a) IN GENERAL.—Subpart D of part IV of sub-  
4 chapter A of chapter 1 of the Internal Revenue Code of  
5 1986 (relating to business related credits) is amended by  
6 adding at the end the following new section:

7 **“SEC. 45N. TELECOMMUNICATIONS CREDIT FOR QUALI-**  
8 **FIED MEDICAL CARE PROVIDERS.**

9 “(a) GENERAL RULE.—For purposes of section 38,  
10 in the case of a qualified medical care provider, the tele-  
11 communications credit determined under this section for  
12 a taxable year is an amount equal to 50 percent of the  
13 applicable telecommunications charges paid or incurred by  
14 such provider during the taxable year.

15 “(b) DOLLAR LIMITATION.—In the case of a qualified  
16 medical care provider, the credit determined under sub-  
17 section (a) for a taxable year shall not exceed \$12,500.

18 “(c) DEFINITIONS.—For purposes of this section—

19 “(1) APPLICABLE TELECOMMUNICATIONS  
20 CHARGES.—The term ‘applicable telecommunications  
21 charges’ means expenses paid or incurred for the  
22 purpose of installing or maintaining a communica-  
23 tions network that supports interoperability of elec-  
24 tronic medical record systems.

25 “(2) QUALIFIED MEDICAL CARE PROVIDER.—  
26 The term ‘qualified medical care provider’ means

1 any person engaged in the trade or business of pro-  
2 viding medical care (as defined in section 213(d))  
3 who has purchased qualified health care information  
4 technology (as defined in section 179(e)).”.

5 (b) CONFORMING AMENDMENTS.—

6 (1) Section 38(b) of such Code is amended by  
7 striking “plus” at the end of paragraph (25), by  
8 striking the period at the end of paragraph (26) and  
9 inserting “, plus”, and by adding at the end the fol-  
10 lowing new paragraph:

11 “(27) the telecommunications credit determined  
12 under section 45N.”.

13 (2) The table of sections for subpart D of part  
14 IV of subchapter A of chapter 1 of such Code is  
15 amended by adding at the end the following new  
16 item:

“Sec. 45N. Telecommunications credit for qualified medical care providers.”.

17 (c) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to expenses paid or incurred after  
19 December 31, 2006.

20 **SEC. 503. DEVELOPMENT OF HEALTH CARE INFORMATION**  
21 **TECHNOLOGY STANDARDS.**

22 Not later than 5 years after the date of the enact-  
23 ment of this Act, the Secretary of Health and Human  
24 Services shall develop standards for health information  
25 technology, including for qualified health care information

1 technology (as defined in section 179(e)(2)(A) of the In-  
 2 ternal Revenue Code of 1986, as added by section 501(a)).

3 **TITLE VI—MEDICAL LIABILITY**  
 4 **REFORMS**

5 **SEC. 601. CONSTITUTIONAL AUTHORITY.**

6 The constitutional authority upon which this title  
 7 rests is the power of the Congress to provide for the gen-  
 8 eral welfare, to regulate commerce, and to make all laws  
 9 which shall be necessary and proper for carrying into exe-  
 10 cution Federal powers, as enumerated in section 8 of arti-  
 11 cle I of the Constitution of the United States.

12 **SEC. 602. PROTECTION AGAINST LEGAL LIABILITY FOR**  
 13 **EMERGENCY AND RELATED SERVICES FUR-**  
 14 **NISHED TO ANY INDIVIDUAL.**

15 Section 224(g) of the Public Health Service Act (42  
 16 U.S.C. 233(g)) is amended—

17 (1) in paragraph (4), by striking “An entity”  
 18 and inserting in lieu thereof “Subject to paragraph  
 19 (6), an entity”; and

20 (2) by adding at the end the following:

21 “(6)(A) For purposes of this section—

22 “(i) an entity described in subparagraph (B)  
 23 shall be considered to be an entity described in para-  
 24 graph (4); and

1           “(ii) the provisions of this section shall apply to  
2           an entity described in subparagraph (B) in the same  
3           manner as such provisions apply to an entity de-  
4           scribed in paragraph (4), except that—

5                   “(I) notwithstanding paragraph (1)(B), the  
6                   deeming of any entity described in subpara-  
7                   graph (B), or of an officer, governing board  
8                   member, employee, or contractor of such an en-  
9                   tity, to be an employee of the Public Health  
10                  Service for purposes of this section shall apply  
11                  only with respect to items and services that are  
12                  furnished to an individual pursuant to section  
13                  1867 of the Social Security Act and to post-sta-  
14                  bilization services (as defined in subparagraph  
15                  (C)) furnished to such an individual;

16                  “(II) nothing in paragraph (1)(D) shall be  
17                  construed as preventing a physician or physi-  
18                  cian group described in subparagraph (B)(ii)  
19                  from making the application referred to in such  
20                  paragraph or as conditioning the deeming of a  
21                  physician or physician group that makes such  
22                  an application upon receipt by the Secretary of  
23                  an application from the hospital or emergency  
24                  department that employs or contracts with the  
25                  physician or group;

1           “(III) notwithstanding paragraph (3), this  
2 paragraph shall apply only with respect to  
3 causes of action arising from acts or omissions  
4 that occur on or after January 1, 2008;

5           “(IV) paragraph (5) shall not apply to a  
6 physician or physician group described in sub-  
7 paragraph (B)(ii);

8           “(V) the Attorney General, in consultation  
9 with the Secretary, shall make separate esti-  
10 mates under subsection (k)(1) with respect to  
11 entities described in subparagraph (B) and enti-  
12 ties described in paragraph (4) (other than  
13 those described in subparagraph (B)), and the  
14 Secretary shall establish separate funds under  
15 subsection (k)(2) with respect to such groups of  
16 entities, and any appropriations under this sub-  
17 section for entities described in subparagraph  
18 (B) shall be separate from the amounts author-  
19 ized by subsection (k)(2);

20           “(VI) notwithstanding subsection (k)(2),  
21 the amount of the fund established by the Sec-  
22 retary under such subsection with respect to en-  
23 tities described in subparagraph (B) may ex-  
24 ceed a total of \$10,000,000 for a fiscal year;  
25 and

1                   “(VII) subsection (m) shall not apply to  
2                   entities described in subparagraph (B).

3                   “(B) An entity described in this subparagraph is—

4                   “(i) a hospital or an emergency department to  
5                   which section 1867 of the Social Security Act ap-  
6                   plies; and

7                   “(ii) a physician or physician group that is em-  
8                   ployed by, or under contract with, such hospital or  
9                   department to furnish items and services to individ-  
10                  uals under such section, including so-called ‘on call  
11                  physicians’ .

12                  “(C) For purposes of this paragraph, the term ‘post-  
13                  stabilization services’ means, with respect to an individual  
14                  who has been treated by an entity described in subpara-  
15                  graph (B) for purposes of complying with section 1867  
16                  of the Social Security Act, services that are—

17                  “(i) related to the condition that was so treated;  
18                  and

19                  “(ii) provided after the individual is stabilized  
20                  in order to maintain the stabilized condition or to  
21                  improve or resolve the individual’s condition.

22                  “(D)(i) Nothing in this paragraph (or in any other  
23                  provision of this section as such provision applies to enti-  
24                  ties described in subparagraph (B) by operation of sub-  
25                  paragraph (A)) shall be construed as authorizing or re-

1 quiring the Secretary to make payments to such entities,  
2 the budget authority for which is not provided in advance  
3 by appropriation Acts.

4 “(ii) The Secretary shall limit the total amount of  
5 payments under this paragraph for a fiscal year to the  
6 total amount appropriated in advance by appropriation  
7 Acts for such purpose for such fiscal year. If the total  
8 amount of payments that would otherwise be made under  
9 this paragraph for a fiscal year exceeds such total amount  
10 appropriated, the Secretary shall take such steps as may  
11 be necessary to ensure that the total amount of payments  
12 under this paragraph for such fiscal year does not exceed  
13 such total amount appropriated.”.

14 **TITLE VII—TAX DEDUCTION FOR**  
15 **UNCOMPENSATED CARE IN**  
16 **EMERGENCY ROOMS**

17 **SEC. 701. BAD DEBT DEDUCTION FOR DOCTORS TO PAR-**  
18 **TIALLY OFFSET THE COST OF PROVIDING UN-**  
19 **COMPENSATED CARE REQUIRED TO BE PRO-**  
20 **VIDED UNDER AMENDMENTS MADE BY THE**  
21 **EMERGENCY MEDICAL TREATMENT AND**  
22 **LABOR ACT.**

23 (a) IN GENERAL.—Section 166 of the Internal Rev-  
24 enue Code of 1986 (relating to bad debts) is amended by

1 redesignating subsection (f) as subsection (g) and by in-  
2 serting after subsection (e) the following new subsection:

3 “(f) BAD DEBT TREATMENT FOR DOCTORS TO PAR-  
4 Tially OFFSET COST OF PROVIDING UNCOMPENSATED  
5 CARE REQUIRED TO BE PROVIDED.—

6 “(1) AMOUNT OF DEDUCTION.—

7 “(A) IN GENERAL.—For purposes of sub-  
8 section (a), the basis for determining the  
9 amount of any deduction for an eligible  
10 EMTALA debt shall be treated as being equal  
11 to the Medicare payment amount.

12 “(B) MEDICARE PAYMENT AMOUNT.—For  
13 purposes of subparagraph (A), the Medicare  
14 payment amount with respect to an eligible  
15 EMTALA debt is the fee schedule amount es-  
16 tablished under section 1848 of the Social Secu-  
17 rity Act for the physicians’ service (to which  
18 such debt relates) as if the service were pro-  
19 vided to an individual enrolled under part B of  
20 title XVIII of such Act.

21 “(2) ELIGIBLE EMTALA DEBT.—For purposes  
22 of this section, the term ‘eligible EMTALA debt’  
23 means any debt if—

24 “(A) such debt arose as a result of physi-  
25 cians’ services—

1           “(i) which were performed in an  
2           EMTALA hospital by a board-certified  
3           physician (whether as part of medical  
4           screening or necessary stabilizing treat-  
5           ment and whether as an emergency depart-  
6           ment physician, as an on-call physician, or  
7           otherwise), and

8           “(ii) which were required to be pro-  
9           vided under section 1867 of the Social Se-  
10          curity Act (42 U.S.C. 1395dd), and

11          “(B) such debt is owed—

12                 “(i) to such physician, or

13                 “(ii) to an entity if—

14                         “(I) such entity is a corporation  
15                         and the sole shareholder of such cor-  
16                         poration is such physician, or

17                         “(II) such entity is a partnership  
18                         and any deduction under this sub-  
19                         section with respect to such debt is al-  
20                         located to such physician or to an en-  
21                         tity described in subclause (I).

22          “(3) BOARD-CERTIFIED PHYSICIAN.—For pur-  
23          poses of this subsection, the term ‘board-certified  
24          physician’ means any physician (as defined in sec-  
25          tion 1861(r) of the Social Security Act (42 U.S.C.

1 1395x(r)) who is certified by the American Board of  
2 Emergency Medicine or other appropriate medical  
3 specialty board for the specialty in which the physi-  
4 cian practices, or who meets comparable require-  
5 ments, as identified by the Secretary of the Treasury  
6 in consultation with Secretary of Health and Human  
7 Services.

8 “(4) OTHER DEFINITIONS.—For purposes of  
9 this subsection—

10 “(A) EMTALA HOSPITAL.—The term  
11 ‘EMTALA hospital’ means any hospital having  
12 a hospital emergency department which is re-  
13 quired to comply with section 1867 of the So-  
14 cial Security Act (42 U.S.C. 1395dd) (relating  
15 to examination and treatment for emergency  
16 medical conditions and women in labor).

17 “(B) PHYSICIANS’ SERVICES.—The term  
18 ‘physicians’ services’ has the meaning given  
19 such term in section 1861(q) of the Social Se-  
20 curity Act (42 U.S.C. 1395x(q)).”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to debts arising from services per-  
23 formed in taxable years beginning after the date of the  
24 enactment of this Act.

1           **TITLE VIII—ADDITIONAL**  
2                           **CHANGES**

3   **SEC. 801. APPLICATION OF SECTION 1115 WAIVERS BY**  
4                           **OTHER STATES.**

5           Section 1115 of the Social Security Act (42 U.S.C.  
6 1315) is amended by adding at the end the following new  
7 subsection:

8           “(g) If the Secretary has waived under subsection (a)  
9 compliance with one or more requirements of title XIX  
10 in connection with a project of a State and such waiver  
11 has not been terminated, the Secretary shall also waive  
12 compliance with such requirements in connection with a  
13 project conducted by another State that is consistent with  
14 the terms and conditions for the original project.”.

15   **SEC. 802. HIPAA TECHNICAL ADVISORY GROUP.**

16           (a) ESTABLISHMENT.—The Secretary shall establish  
17 a Technical Advisory Group (in this section referred to  
18 as the “Advisory Group”) to review issues related to the  
19 HIPAA regulations and their implementation. In this sec-  
20 tion, the term “HIPAA regulations” refers to the regula-  
21 tions promulgated pursuant to section 264(c) of the  
22 Health Insurance Portability and Accountability Act of  
23 1996 (42 U.S.C. 1320d–1 note).

24           (b) MEMBERSHIP.—The Advisory Group shall be  
25 composed of 19 members, including the Administrator of

1 the Centers for Medicare & Medicaid Services and the In-  
2 spector General of the Department of Health and Human  
3 Services and of which—

4 (1) 2 shall be representatives of hospitals, in-  
5 cluding at least one public hospital, that have experi-  
6 ence with the application of HIPAA regulations;

7 (2) 9 shall be practicing physicians drawn from  
8 the fields of emergency medicine, cardiology or  
9 cardiothoracic surgery, orthopaedic surgery, neuro-  
10 surgery, general surgery with expertise in trauma,  
11 internal medicine, pediatrics or a pediatric sub-  
12 specialty, obstetrics-gynecology, and psychiatry, with  
13 not more than one physician from any particular  
14 field;

15 (3) 2 shall be non-physician representatives  
16 from private medical practices with significant pa-  
17 tient volume;

18 (4) 2 shall represent patients;

19 (5) 2 shall be staff involved in HIPAA regula-  
20 tions investigations from different regional offices of  
21 the Centers for Medicare & Medicaid Services; and

22 (6) 1 shall be from a State survey office in-  
23 volved in HIPAA regulations investigations and 1  
24 shall be from a peer review organization, both of

1 whom shall be from areas other than the regions  
2 represented under paragraph (5).

3 In selecting members described in paragraphs (1) through  
4 (4), the Secretary shall consider qualified individuals nom-  
5 inated by organizations representing providers and pa-  
6 tients.

7 (c) GENERAL RESPONSIBILITIES.—The Advisory  
8 Group—

9 (1) shall review HIPAA regulations;

10 (2) may provide advice and recommendations to  
11 the Secretary with respect to those regulations and  
12 their application to hospitals, medical practices, out-  
13 patient services and physicians;

14 (3) shall solicit comments and recommendations  
15 from hospitals, physicians, and the public regarding  
16 the implementation of such regulations;

17 (4) may disseminate information on the applica-  
18 tion of such regulations to hospitals, physicians, and  
19 the public; and

20 (5) shall make recommendations to Congress  
21 regarding any reforms recommended that may ease  
22 the regulatory burden on those caring for patients.

23 (d) ADMINISTRATIVE MATTERS.—

24 (1) CHAIRPERSON.—The members of the Advi-  
25 sory Group shall elect a member to serve as chair-

1 person of the Advisory Group for the life of the Ad-  
2 visory Group.

3 (2) MEETINGS.—The Advisory Group shall first  
4 meet at the direction of the Secretary. The Advisory  
5 Group shall then meet twice per year and at such  
6 other times as the Advisory Group may provide.

7 (e) TERMINATION.—The Advisory Group shall termi-  
8 nate 30 months after the date of its first meeting.

9 (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The  
10 Secretary shall establish the Advisory Group notwith-  
11 standing any limitation that may apply to the number of  
12 advisory committees that may be established (within the  
13 Department of Health and Human Services or otherwise).

14 **SEC. 803. MEDICARE PHYSICIAN PAYMENT UPDATE RE-**  
15 **FORM.**

16 (a) SUBSTITUTION OF MEI INCREASE FOR SGR AD-  
17 JUSTMENTS.—Section 1848(d) of the Social Security Act  
18 (42 U.S.C. 1395w–4(d)) is amended—

19 (1) in paragraph (1)(A), by inserting “and be-  
20 fore 2008” after “beginning with 2001”;

21 (2) in paragraph (1)(A), by inserting before the  
22 period at the end the following: “, and for years be-  
23 ginning with 2008, multiplied by the update estab-  
24 lished under paragraph (7) applicable to the year in-  
25 volved”; and

1 (3) in paragraph (4)—

2 (A) in the heading by striking “YEARS BE-  
3 GINNING WITH 2001” and inserting “2001, 2002,  
4 AND 2003”; and

5 (B) in subparagraph (A), by inserting  
6 “and ending with 2003” after “beginning with  
7 2001”; and

8 (4) by adding at the end the following new  
9 paragraph:

10 “(8) UPDATE BEGINNING WITH 2008.—The up-  
11 date to the single conversion factor established in  
12 paragraph (1)(C) for 2008 and each succeeding year  
13 shall be the percentage increase in the MEI (as de-  
14 fined in section 1842(i)(3)) for the year involved.”.

15 (b) ENDING APPLICATION OF SUSTAINABLE  
16 GROWTH RATE (SGR).—Section 1848(f)(1)(B) of such  
17 Act (42 U.S.C. 1395w-4(f)(1)(B)) is amended by insert-  
18 ing “(and before 2007)” after “each succeeding year”.

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to payment for services furnished  
21 on or after January 1, 2008.

22 **SEC. 804. REMOVING LIMITATIONS ON BALANCE BILLING**  
23 **WITH BENEFICIARY NOTICE.**

24 (a) IN GENERAL.—Section 1848(g) of the Social Se-  
25 curity Act (42 U.S.C. 1395w-4(g)) is amended—

1 (1) in paragraph (1)(A), in the matter before  
2 clause (i), by inserting “, subject to subparagraph  
3 (D),” after “enrolled under this part”;

4 (2) in paragraph (1), by adding at the end the  
5 following new subparagraph:

6 “(D) EXCEPTION.—Subparagraph (A)  
7 shall not apply with respect to physicians’ serv-  
8 ices furnished in a month to an individual if the  
9 individual furnishing such services provides the  
10 advance notice of such non-participation and  
11 non-acceptance of assignment under paragraph  
12 (8) and (for services furnished on or after Jan-  
13 uary 1, 2008) submits information in accord-  
14 ance with subsection (k)(4).”; and

15 (3) by adding at the end the following new  
16 paragraph:

17 “(8) NOTICE OF NON-PARTICIPATION AND NON-  
18 ACCEPTANCE OF ASSIGNMENT.—For purposes of  
19 paragraph (1)(D), the advance notice of non-partici-  
20 pation and non-acceptance of assignment shall be,  
21 with respect to an item or service furnished under  
22 this part by (or under the supervision of) a physi-  
23 cian, a notice (that may be in the form of a posting  
24 in a conspicuous place in a physician’s office or on  
25 patient information forms) that is posted or other-

1 wise furnished in a manner so as to inform the indi-  
2 vidual receiving the item or service that—

3 “(A) the physician furnishing (or super-  
4 vising the furnishing of) the items or service is  
5 not a participating physician and does not ac-  
6 cept assignment with respect to the service; and

7 “(B) because of such non-acceptance, in  
8 the case of physicians’ services furnished in a  
9 month to an individual, the charge imposed is  
10 not limited and may exceed the limiting charge  
11 described in paragraph (2).”.

12 (b) CONFORMING AMENDMENT TO PRIVATE CON-  
13 TRACT PROVISIONS.—Section 1802 of such Act (42  
14 U.S.C. 1395a) is amended by adding at the end the fol-  
15 lowing new paragraph:

16 “(6) EXCEPTION.—The previous provisions of  
17 this subsection shall not apply to physicians’ services  
18 furnished in a month to an individual if the advance  
19 notice described in section 1848(g)(8) has been pro-  
20 vided and (for services furnished on or after Janu-  
21 ary 1, 2008) the physician furnishing the services  
22 submits information in accordance with section  
23 1848(k)(4).”.

24 (c) CONFORMING AMENDMENT TO PARTICIPATION  
25 PROVISIONS.—Section 1842(h) of such Act (42 U.S.C.

1 1395u) is amended by adding at the end the following new  
2 paragraph:

3 “(8) The previous provisions of this subsection, inso-  
4 far as they limit the charges that a participating physician  
5 may impose, shall not apply to physicians’ services fur-  
6 nished in a month to an individual if the advance notice  
7 described in section 1848(g)(8) has been provided and (for  
8 services furnished on or after January 1, 2008) the physi-  
9 cian furnishing the services submits information in accord-  
10 ance with section 1848(k)(4).”.

11 (d) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to services furnished on or after  
13 January 1, 2008.

14 **SEC. 805. ELECTION OF TAX CREDIT INSTEAD OF ALTER-**  
15 **NATIVE GOVERNMENT BENEFITS.**

16 (a) IN GENERAL.—Notwithstanding any other provi-  
17 sion of law, an individual who is otherwise eligible for ben-  
18 efits under a Federal health program (as defined in sub-  
19 section (c)) may elect, in a form and manner specified by  
20 the Secretary of Health and Human Services in consulta-  
21 tion with the Secretary of the Treasury, to receive a tax  
22 credit described in section 36 of the Internal Revenue  
23 Code of 1986 (which may be used for the purpose of  
24 health insurance coverage) in lieu of receiving any benefits  
25 under such program.

1 (b) EFFECTIVE DATE.—An election under subsection  
2 (a) may first be made for calendar year 2009 and any  
3 such election shall be effective for such period (not less  
4 than one calendar year) as the Secretary of Health and  
5 Human Services shall specify, in consultation with the  
6 Secretary of the Treasury.

7 (c) FEDERAL HEALTH PROGRAM DEFINED.—For  
8 purposes of this section, the term “Federal health pro-  
9 gram” means any of the following:

10 (1) MEDICARE.—The medicare program under  
11 part A of title XVIII of the Social Security Act, in-  
12 cluding any benefits under any other part of such  
13 title.

14 (2) MEDICAID.—The Medicaid program under  
15 title XIX of such Act (including such a program op-  
16 erating under a Statewide waiver under section 1115  
17 of such Act).

18 (3) SCHIP.—The State children’s health insur-  
19 ance program under title XXI of such Act.

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

22 (5) VETERANS BENEFITS.—Coverage for bene-  
23 fits under chapter 17 of title 38, United States  
24 Code.

1 **SEC. 806. USE OF PRIVATE CONTRACTS BY MEDICARE**  
2 **BENEFICIARIES FOR PROFESSIONAL SERV-**  
3 **ICES.**

4 (a) IN GENERAL.—Section 1802 of the Social Secu-  
5 rity Act (42 U.S.C. 1395a) is amended by striking sub-  
6 section (b) and inserting the following:

7 “(b) CLARIFICATION OF USE OF PRIVATE CON-  
8 TRACTS BY MEDICARE BENEFICIARIES FOR PROFES-  
9 SIONAL SERVICES.—

10 “(1) IN GENERAL.—Nothing in this title shall  
11 prohibit a medicare beneficiary from entering into a  
12 private contract with a physician or health care  
13 practitioner for the provision of medicare covered  
14 professional services (as defined in paragraph  
15 (5)(C)) if—

16 “(A) the services are covered under a pri-  
17 vate contract that is between the beneficiary  
18 and the physician or practitioner and meets the  
19 requirements of paragraph (2);

20 “(B) under the private contract no claim  
21 for payment for services covered under the con-  
22 tract is to be submitted (and no payment made)  
23 under part A or B under a contract under sec-  
24 tion 1876, or under a Medicare Advantage plan  
25 (other than an MSA plan); and

1           “(C)(i) the Secretary has been provided  
2 with the minimum information necessary to  
3 avoid any payment under part A or B for serv-  
4 ices covered under the contract, or

5           “(ii) in the case of an individual enrolled  
6 under a contract under section 1876 or a Medi-  
7 care Advantage plan (other than an MSA plan)  
8 under part C, the eligible organization under  
9 the contract or the Medicare Advantage organi-  
10 zation offering the plan has been provided the  
11 minimum information necessary to avoid any  
12 payment under such contract or plan for serv-  
13 ices covered under the contract.

14           “(2) REQUIREMENTS FOR PRIVATE CON-  
15 TRACTS.—The requirements in this paragraph for a  
16 private contract between a medicare beneficiary and  
17 a physician or health care practitioner are as fol-  
18 lows:

19           “(A) GENERAL FORM OF CONTRACT.—The  
20 contract is in writing and is signed by the medi-  
21 care beneficiary.

22           “(B) NO CLAIMS TO BE SUBMITTED FOR  
23 COVERED SERVICES.—The contract provides  
24 that no party to the contract (and no entity on  
25 behalf of any party to the contract) shall sub-

1 mit any claim for (or request) payment for  
2 services covered under the contract under part  
3 A or B, under a contract under section 1876,  
4 or under a Medicare Advantage plan (other  
5 than an MSA plan).

6 “(C) SCOPE OF SERVICES.—The contract  
7 identifies the medicare covered professional  
8 services and the period (if any) to be covered  
9 under the contract, but does not cover any serv-  
10 ices furnished—

11 “(i) before the contract is entered  
12 into; or

13 “(ii) for the treatment of an emer-  
14 gency medical condition (as defined in sec-  
15 tion 1867(e)(1)(A)), unless the contract  
16 was entered into before the onset of the  
17 emergency medical condition.

18 “(D) CLEAR DISCLOSURE OF TERMS.—The  
19 contract clearly indicates that by signing the  
20 contract the medicare beneficiary—

21 “(i) agrees not to submit a claim (or  
22 to request that anyone submit a claim)  
23 under part A or B (or under section 1876  
24 or under a Medicare Advantage plan, other

1 than an MSA plan) for services covered  
2 under the contract;

3 “(ii) agrees to be responsible, whether  
4 through insurance or otherwise, for pay-  
5 ment for such services and understands  
6 that no reimbursement will be provided  
7 under such part, contract, or plan for such  
8 services;

9 “(iii) acknowledges that no limits  
10 under this title (including limits under  
11 paragraph (1) and (3) of section 1848(g))  
12 will apply to amounts that may be charged  
13 for such services;

14 “(iv) acknowledges that medicare sup-  
15 plemental policies under section 1882 do  
16 not, and other supplemental health plans  
17 and policies may elect not to, make pay-  
18 ments for such services because payment is  
19 not made under this title; and

20 “(v) acknowledges that the beneficiary  
21 has the right to have such services pro-  
22 vided by (or under the supervision of)  
23 other physicians or health care practi-  
24 tioners for whom payment would be made  
25 under such part, contract, or plan.

1           Such contract shall also clearly indicate whether  
2           the physician or practitioner involved is ex-  
3           cluded from participation under this title.

4           “(3) MODIFICATIONS.—The parties to a private  
5           contract may mutually agree at any time to modify  
6           or terminate the contract on a prospective basis,  
7           consistent with the provisions of paragraphs (1) and  
8           (2).

9           “(4) NO REQUIREMENTS FOR SERVICES FUR-  
10          NISHED TO MSA PLAN ENROLLEES.—The require-  
11          ments of paragraphs (1) and (2) do not apply to any  
12          contract or arrangement for the provision of services  
13          to a medicare beneficiary enrolled in an MSA plan  
14          under part C.

15          “(5) DEFINITIONS.—In this subsection:

16                 “(A) HEALTH CARE PRACTITIONER.—The  
17                 term ‘health care practitioner’ means a practi-  
18                 tioner described in section 1842(b)(18)(C).

19                 “(B) MEDICARE BENEFICIARY.—The term  
20                 ‘medicare beneficiary’ means an individual who  
21                 is enrolled under part B.

22                 “(C) MEDICARE COVERED PROFESSIONAL  
23                 SERVICES.—The term ‘medicare covered profes-  
24                 sional services’ means—

1 “(i) physicians’ services (as defined in  
2 section 1861(q), and including services de-  
3 scribed in section 1861(s)(2)(A)), and

4 “(ii) professional services of health  
5 care practitioners, including services de-  
6 scribed in section 1842(b)(18)(D),

7 for which payment may be made under part A  
8 or B, under a contract under section 1876, or  
9 under a Medicare Advantage plan but for the  
10 provisions of a private contract that meets the  
11 requirements of paragraph (2).

12 “(D) MEDICARE ADVANTAGE PLAN; MSA  
13 PLAN.—The terms ‘Medicare Advantage plan’  
14 and ‘MSA plan’ have the meanings given the  
15 terms ‘Medicare+Choice plan’ and ‘MSA plan’  
16 in section 1859.

17 “(E) PHYSICIAN.—The term ‘physician’  
18 has the meaning given such term in section  
19 1861(r).”.

20 (b) CONFORMING AMENDMENTS CLARIFYING EX-  
21 EMPTION FROM LIMITING CHARGE AND FROM REQUIRE-  
22 MENT FOR SUBMISSION OF CLAIMS.—Section 1848(g) of  
23 the Social Security Act (42 U.S.C. 1395w-4(g)) is amend-  
24 ed—

1           (1) in paragraph (1)(A), by striking “In” and  
2           inserting “Subject to paragraph (8), in”;

3           (2) in paragraph (3)(A), by striking “Payment”  
4           and inserting “Subject to paragraph (8), payment”;

5           (3) in paragraph (4)(A), by striking “For” and  
6           inserting “Subject to paragraph (8), for”; and

7           (4) by adding at the end the following new  
8           paragraph:

9           “(8) EXEMPTION FROM REQUIREMENTS FOR  
10          SERVICES FURNISHED UNDER PRIVATE CON-  
11          TRACTS.—

12                 “(A) IN GENERAL.—Pursuant to section  
13                 1802(b)(1), paragraphs (1), (3), and (4) do not  
14                 apply with respect to physicians’ services (and  
15                 services described in section 1861(s)(2)(A)) fur-  
16                 nished to an individual by (or under the super-  
17                 vision of) a physician if the conditions described  
18                 in section 1802(b)(1) are met with respect to  
19                 the services.

20                 “(B) NO RESTRICTIONS FOR ENROLLEES  
21                 IN MSA PLANS.—Such paragraphs do not apply  
22                 with respect to services furnished to individuals  
23                 enrolled with MSA plans under part C, without  
24                 regard to whether the conditions described in

1           subparagraphs (A) through (C) of section  
2           1802(b)(1) are met.

3           “(C) APPLICATION TO ENROLLEES IN  
4           OTHER PLANS.—Subject to subparagraph (B)  
5           and section 1852(k)(2), the provisions of sub-  
6           paragraph (A) shall apply in the case of an in-  
7           dividual enrolled under a contract under section  
8           1876 or under a Medicare Advantage plan  
9           (other than an MSA plan) under part C, in the  
10          same manner as they apply to individuals not  
11          enrolled under such a contract or plan.”.

12          (c) CONFORMING AMENDMENTS.—

13           (1) Section 1842(b)(18) of the Social Security  
14          Act (42 U.S.C. 1395u(b)(18)) is amended by adding  
15          at the end the following:

16           “(E) The provisions of section 1848(g)(8)  
17          shall apply with respect to exemption from limi-  
18          tations on charges and from billing require-  
19          ments for services of health care practitioners  
20          described in this paragraph in the same manner  
21          as such provisions apply to exemption from the  
22          requirements referred to in section  
23          1848(g)(8)(A) for physicians’ services.”.

24           (2) Section 1866(a)(1)(O) of such Act (42  
25          U.S.C. 1395cc(a)(1)(O)) is amended by inserting

1 “(other than under an MSA plan)” after  
2 “Medicare+Choice organization under part C”.

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall be effective on the date of the enactment  
5 of this Act.

6 **SEC. 807. EMTALA TECHNICAL ADVISORY GROUP.**

7 (a) AUTHORIZATION FOR EXTENSION.—Subsection  
8 (e) of section 945 of the Medicare Prescription Drug, Im-  
9 provement, and Modernization Act of 2003 (Public Law  
10 108–173; 42 U.S.C. 1395dd note) is amended by inserting  
11 before the period at the end the following: “, except that  
12 the Secretary may extend the Advisory Group beyond such  
13 date in order to permit the Advisory Group to continue  
14 to carry out its responsibilities”.

15 (b) SECRETARIAL RESPONSIVE REPORT ON GROUP  
16 RECOMMENDATIONS.—Such section is further amended  
17 by adding at the end the following new subsection:

18 “(g) SECRETARIAL RESPONSE TO RECOMMENDA-  
19 TIONS.—The Secretary shall review the recommendations  
20 made to the Secretary by the Advisory Group and shall  
21 submit to Congress a report that contains a description  
22 of any actions the Secretary intends to take in response  
23 to such recommendations and problems identified by the  
24 Advisory Group with regard to the EMTALA regulations  
25 and their application.”.

1 **SEC. 808. FEDERALLY-SUPPORTED STUDENT LOAN FUNDS**  
2 **FOR MEDICAL STUDENTS.**

3 (a) PRIMARY HEALTH CARE MEDICAL STUDENTS.—  
4 Subpart II of part A of the Public Health Service Act (42  
5 U.S.C. 292q et seq.) is amended—

6 (1) by redesignating section 735 as section 729;  
7 and

8 (2) in subsection (f) of section 729 (as so reded-  
9 igned), by striking “is authorized to be appro-  
10 priated to be appropriated \$10,000,000 for each of  
11 the fiscal years 1994 through 1996” and inserting  
12 “are authorized to be appropriated such sums as  
13 may be necessary for fiscal year 2008 and each fis-  
14 cal year thereafter”.

15 (b) OTHER MEDICAL STUDENTS.—Part A of title VII  
16 of the Public Health Service Act (42 U.S.C. 292 et seq.)  
17 is amended by adding at the end the following:

18 **“Subpart III—Federally-Supported Student Loan**  
19 **Funds for Certain Medical Students**

20 **“SEC. 730. SCHOOL LOAN FUNDS FOR CERTAIN MEDICAL**  
21 **STUDENTS.**

22 “(a) FUND AGREEMENTS.—For the purpose de-  
23 scribed in subsection (b), the Secretary is authorized to  
24 enter into an agreement for the establishment and oper-  
25 ation of a student loan fund with any public or nonprofit  
26 school of medicine or osteopathic medicine.

1       “(b) PURPOSE.—The purpose of this subpart is to  
2 provide for loans to medical students who would be eligible  
3 for a loan under subpart II, except for the student’s deci-  
4 sion to enter a residency training program in a field other  
5 than primary health care.

6       “(c) COMMENCEMENT OF REPAYMENT PERIOD.—  
7 The repayment period for a loan under this section shall  
8 not begin before the end of any period during which the  
9 student is participating in an internship, residency, or fel-  
10 lowship training program directly related to the field of  
11 medicine which the student agrees to enter pursuant to  
12 subsection (d).

13       “(d) REQUIREMENTS FOR STUDENTS.—Each agree-  
14 ment under this section for the establishment of a student  
15 loan fund shall provide that the school of medicine or os-  
16 teopathic medicine will make a loan to a student from such  
17 fund only if the student agrees—

18               “(1) to enter and complete a residency training  
19 program (in a field of medicine other than primary  
20 health care) not later than a period determined by  
21 the Secretary to be reasonable after the date on  
22 which the student graduates from such school; and

23               “(2) to practice medicine through the date on  
24 which the loan is repaid in full.

1       “(e) REQUIREMENTS FOR SCHOOLS.—The provisions  
2 of section 723(b) (regarding graduates in primary health  
3 care) shall not apply to a student loan fund established  
4 under this section.

5       “(f) APPLICABILITY OF OTHER PROVISIONS.—Ex-  
6 cept as inconsistent with this section, the provisions of  
7 subpart II shall apply to the program of student loan  
8 funds established under this section to the same extent  
9 and in the same manner as such provisions apply to the  
10 program of student loan funds established under subpart  
11 II.

12       “(g) AUTHORIZATION OF APPROPRIATIONS.—To  
13 carry out this section, there are authorized to be appro-  
14 priated such sums as may be necessary for fiscal year  
15 2008 and each fiscal year thereafter.”.

16 **SEC. 809. ESTABLISHMENT OF PERFORMANCE-BASED**  
17 **QUALITY MEASURES.**

18       Not later than January 1, 2009, the Secretary of  
19 Health and Human Services shall submit to Congress a  
20 proposal for a formalized process for the development of  
21 performance-based quality measures that could be applied  
22 to physicians’ services under the Medicare program. Such  
23 proposal shall be in concert with and agreement with the  
24 Physician Consortium for Performance Improvement and

- 1 shall only utilize measures agreed upon by each physician
- 2 specialty group.

