I

110TH CONGRESS
1ST SESSION

H. R. 2626

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

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.

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

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

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Health Coverage And Reform Enhancement Act of 2007'' or as the ''Comprehensive HealthCARE Act of 2007''.

(b) FINDINGS.—Congress finds the following:

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

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

(3) In 2005, the total national health expenditures rose 6.9 percent—two times the rate of inflation. Total health care spending represented 16 percent of the gross domestic product (GDP).

(4) Census data show that 46.6 million Americans were uninsured at some point in 2005, an increase of 1.3 million from the comparable number of uninsured in 2004 (45.3 million). This percentage rose from 15.6 percent in 2004 to 15.9 percent in 2005.

(5) Lack of insurance is much more common among people with low incomes. Some 24.4 percent of people with incomes below $25,000 were uninsured in 2005, almost triple the rate of 8.5 percent among people with incomes over $75,000.

(6) National surveys show that the primary reason people are uninsured is the high cost of health insurance coverage.

(7) The percentage of Americans who are uninsured continues to rise due to a decrease of employees with employer-sponsored coverage.

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

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

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

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

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

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

(13) With both government and employer provided health care, there is a lack of individual ownership and personal choice for patients.

(14) There are 18 million Americans who purchase health insurance on their own and currently, these individuals pay higher taxes than those who get insurance through their employer, due to the tax deductibility allowed to the employer for the purchase pf health insurance.

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

(16) Health insurers would be more responsive to individuals and families if health insurance policies were owned by the person most directly affected by the coverage—the patient.

(17) Providing individuals and families with various options to help them secure and maintain personal, defined contribution coverage of their choice, would make health care coverage more affordable and accessible for all Americans.

(18) It is appropriate to encourage increased efficiency in the offering of health insurance coverage through a collaborative approach by the States in regulating this coverage.

(19) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail; all of which are inherently part of interstate commerce.

(20) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(21) Our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care. The health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and appropriately compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality health care.

(22) Permitting health care professionals to negotiate collectively with health care plans will create a more equal balance of negotiating power, will promote competition, and will enhance the quality of patient care.

(23) The benefits of an electronic healthcare information system include improved quality of care, reduced costs associated with medication errors, more accurate and complete medical documentation, more accurate capture of codes and charges, and improved communication among providers enabling them to respond more quickly to patients' needs and increase health care quality.

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

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

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

with other financial responsibilities from attending medical school.

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

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

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

(30) Nationally, more than 35 percent of emergency department patients are uninsured or are Medicaid or SCHIP enrollees.

(31) Strain on emergency departments is due to multiple factors, including the shortage of nurses and on-call physicians, a decrease in the total number of community hospitals, and high levels of bad debt incurred as a result of providing care to indigent patients.

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

health insurance, and the rising number of uninsured, the imperative for comprehensive health system reform is readily apparent.

(33) Patient access to quality care has been harmed by decreasing compensation to physicians through a flawed Medicare sustainable growth rate (SGR) system that fails to appropriately account for severity of illness, intensity of treatment, medical inflation, or costs.

(34) Decisions regarding health care are often the most personal and important made in an individual's life, however these decisions are increasingly being made without appropriate input by either patients or health care providers.

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

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

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH INSURANCE COVERAGE

SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COSTS OF LOW-INCOME INDIVIDUALS.

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

"SEC. 36. HEALTH INSURANCE COSTS OF LOW-INCOME INDIVIDUALS.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A the aggregate amount paid by the taxpayer for coverage of the taxpayer and the taxpayer's qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

"(b) LIMITATIONS.—

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

not exceed the sum of the monthly limitations for months during such taxable year that the taxpayer or the taxpayer's qualifying family members is an eligible individual.

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is the credit percentage of 1/12 of the sum of—

"(A) $4,000 for coverage of the taxpayer,

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

"(C) $2,000 for coverage of each dependent of the taxpayer.

"(3) CREDIT PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this section, the term 'credit percentage' means 90 percent reduced by 1 percentage point for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the threshold amount.

"(B) THRESHOLD AMOUNT.—For purposes of this paragraph, the term 'threshold amount' means, with respect to any taxpayer for any taxable year, the sum of—

"(i) $20,000,

"(ii) in the case of a joint return, $6,000, and

"(iii) $5,000 for each dependent of the taxpayer.

"(4) ONLY 2 DEPENDENTS TAKEN INTO ACCOUNT.—Not more than 2 dependents of the taxpayer may be taken into account under paragraphs (2)(C) and (3)(B)(iii).

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

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50.

"(c) ELIGIBLE COVERAGE MONTH.—For purposes of this section, the term 'eligible coverage month' means,

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

''(1) is covered by qualified health insurance,

''(2) does not have other specified coverage, and

''(3) is not imprisoned under Federal, State, or local authority.

''(d) QUALIFYING FAMILY MEMBER.—For purposes of this section, the term 'qualifying family member' means—

''(1) in the case of a joint return, the taxpayer's spouse, and

''(2) any dependent of the taxpayer.

''(e) QUALIFIED HEALTH INSURANCE.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified health insurance' means any insurance which constitutes medical care.

''(2) EXCEPTIONS.—Such term does not include insurance—

''(A) substantially all of the coverage of which is of excepted benefits described in section 9832(c); or

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

section) unless the insurance meets the requirements of paragraph (3).

''(3) INSURANCE REQUIREMENTS.—For purposes of paragraph (2)(B), the requirements of this paragraph with respect to insurance are the following:

''(A) The issuer of the insurance may not decline to offer the insurance, or deny enrollment, of any individual based on any factor described in section 9802(a)(1).

''(B) The insurance conforms to standards (established by the National Association of Insurance Commissioners in consultation with insurance companies and recognized by the Secretary) relating to each of the following:

''(i) Limitation on application of preexisting condition exclusions (as defined in section 9801(b)(1)).

''(ii) Guaranteed renewability.

''(iii) Premium ratings.

''(iv) Risk-spreading.

''(v) Consumer disclosures.

''(vi) Information provided to States and the Federal Government.

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

''(1) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

''(A) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

''(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

''(2) CERTAIN OTHER COVERAGE.—Such individual—

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

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

''(g) SPECIAL RULES.—

''(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT; RECAPTURE OF EXCESS ADVANCE PAYMENTS.—With respect to any taxable year—

''(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced

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

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

''(i) the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, over

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

''(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining—

''(A) any deduction allowed under section 162(l), 213, or 224, or

''(B) any credit allowed under section 35.

''(3) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) or from a health

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

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

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

''(B) a dependent with respect to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(5) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

''(6) TREATMENT OF PAYMENTS.—For purposes of this section—

''(A) PAYMENTS BY SECRETARY.—Payments made by the Secretary on behalf of any individual under section 7529 (relating to ad-

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

''(B) PAYMENTS BY TAXPAYER.—Payments made by the taxpayer for eligible coverage months shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

''(7) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050W, and section 7529.''.

(b) CONFORMING AMENDMENTS.—

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

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating the item relating to section 36 as an item relating to section 37 and by inserting after the item relating to section 35 the following new item:

''Sec. 36. Health insurance costs of low-income individuals.''.

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

SEC. 102. ADVANCE PAYMENT OF CREDIT AS PREMIUM PAYMENT FOR QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following:

"SEC. 7529. ADVANCE PAYMENT OF CREDIT AS PREMIUM PAYMENT FOR QUALIFIED HEALTH INSURANCE.

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

(b) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—

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

''(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The Secretary may, on behalf of taxpayers eligible for the credit under section 36, disclose to a provider of qualified health insurance (as defined in section 36(e)), and persons acting on behalf of such provider, return information with respect to any such taxpayer only to the extent necessary (as prescribed by regulations issued by the Secretary) to carry out the program established by section 7529 (relating to advance payment of credit as premium payment for qualified health insurance).''.

(2) CONFIDENTIALITY OF INFORMATION.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

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

(c) INFORMATION REPORTING.—

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

persons) is amended by adding at the end the following new section:

"SEC. 6050W. RETURNS RELATING TO CREDIT FOR HEALTH INSURANCE COSTS OF LOW-INCOME INDIVIDUALS.

"(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7529 (relating to advance payment of credit as premium payment for qualified health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

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

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

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

"(B) the number of months for which amounts were entitled to be received with respect to such individual under section 7529 (relating to advance payment of credit as premium payment for qualified health insurance),

''(C) the amount entitled to be received for each such month, and

''(D) such other information as the Secretary may prescribe.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

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

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by striking ''or'' at the end of clause (xix), by striking ''and'' at the end of

clause (xx) and inserting ''or'', and by inserting after clause (xx) the following new clause:

''(xxi) section 6050W (relating to returns relating to credit for health insurance costs of low-income individuals), and''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (BB), by striking the period at the end of subparagraph (CC) and inserting '', or'', and by adding after subparagraph (CC) the following new subparagraph:

''(DD) section 6050W (relating to returns relating to credit for health insurance costs of low-income individuals).''.

(d) CLERICAL AMENDMENTS.—

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

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

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

''Sec. 6050W. Returns relating to credit for health insurance costs of low-income individuals.''.

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

SEC. 103. DEDUCTION FOR QUALIFIED HEALTH INSURANCE COSTS OF INDIVIDUALS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. COSTS OF QUALIFIED HEALTH INSURANCE.

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

''(b) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' means insurance which constitutes medical care; except that such term shall not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(c) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for in-

surance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a). Any amount taken into account in determining the credit allowed under section 35 shall not be taken into account for purposes of this section.

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''.

(b) DEDUCTION ALLOWED IN COMPUTING ADJUSTED GROSS INCOME.—Subsection (a) of section 62 of such Code is amended by inserting before the last sentence the following new paragraph:

''(22) COSTS OF QUALIFIED HEALTH INSURANCE.—The deduction allowed by section 224.''.

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

''Sec. 224. Costs of qualified health insurance.''.

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

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

(a) IN GENERAL.—Section 162 of the Internal Revenue Code of 1986 is amended by redesignating subsection (q) as subsection (r) and by inserting after subsection (o) the following new subsection:

''(q) LIMITATION ON DEDUCTION FOR GROUP HEALTH PLAN EXPENSES.—The deduction allowed for any taxable year under this section for any amount paid or incurred in connection with a group health plan (as defined in subsection (n)(3)) shall not exceed the sum of—

''(1) $15,000 for each contract for family coverage under such plan, and

''(2) $7,500 for each contract for self-only coverage under such plan.''.

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

SEC. 105. EQUAL EMPLOYER CONTRIBUTION RULE TO PROMOTE CHOICE.

(a) EXCISE TAX FOR FAILURE TO PROVIDE CONTRIBUTION ELECTION.—

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

"SEC. 5000A. HEALTH CARE CONTRIBUTION ELECTION.

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

"(b) CONTRIBUTION ELECTION.—The requirement of this subsection is met with respect to any individual if such individual may elect to have the employer or employee organization pay an amount which is not less than the contribution amount to any provider of insurance (other than insurance described in section 36(e)(2)) which constitutes medical care of the individual or individual's spouse or dependents in lieu of any group health plan coverage otherwise provided or contributed to by the employer with respect to such individual.

"(c) CONTRIBUTION AMOUNT.—For purposes of this section, the term 'contribution amount' means, with respect to an individual under a group health plan, the por-

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

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

''(e) APPLICATION TO FEHBP.—Notwithstanding any other provision of law, the Office of Personnel Management shall carry out the health benefits program under chapter 89 of title 5, United States Code, consistent with the requirements of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 47 of such Code is amended by inserting after the item relating to section 5000 the following new item:

''Sec. 5000A. Health care contribution election.''.

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

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

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

''(2) the aggregate amount of such contributions is estimated to be equal to the aggregate amount of such contributions if this subsection did not apply.''.

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

''(e) An employer which provides benefits to employees consisting of health insurance coverage, benefits otherwise consisting of medical care, or both, shall not be treated as breaching any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title in the case of one or more of such employees solely because of the extent to which the employer elects to provide, in the case of such one or more employees, some or all of such benefits by means of contributions made under an arrangement which is not a group health plan, irrespective of the extent to which the employer otherwise provides such benefits to employees under a group health plan. For purposes of this subsection, terms used in this subsection which are defined

in section 733 shall have the definitions provided such terms in such section.''.

TITLE II—QUALITY HEALTH-CARE PROFESSIONALS COALITION ACT

SEC. 201. SHORT TITLE.

This title may be cited as the ''Quality Health-Care Coalition Act of 2007''.

SEC. 202. APPLICATION OF THE ANTITRUST LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING WITH HEALTH PLANS.

(a) IN GENERAL.—Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled in connection with such collective bargaining. Such a professional shall, only in connection with such negotiations, be treated as an employee engaged in concerted activities and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor.

(b) PROTECTION FOR GOOD FAITH ACTIONS.—Actions taken in good faith reliance on subsection (a) shall not be the subject under the antitrust laws of criminal sanctions nor of any civil damages, fees, or penalties beyond actual damages incurred.

(c) LIMITATION.—

(1) NO NEW RIGHT FOR COLLECTIVE CESSATION OF SERVICE.—The exemption provided in subsection (a) shall not confer any new right to participate in any collective cessation of service to patients not already permitted by existing law.

(2) NO CHANGE IN NATIONAL LABOR RELATIONS ACT.—This section applies only to health care professionals excluded from the National Labor Relations Act. Nothing in this section shall be construed as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.

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

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

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

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

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

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

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

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

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

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

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

(h) EXEMPTION OF ABORTION AND ABORTION SERVICES.—Nothing in this section shall apply to negotiations specifically relating to requiring a health plan to cover abortion or abortion services.

(i) GENERAL ACCOUNTING OFFICE STUDY AND REPORT.—The Comptroller General of the United States shall conduct a study on the impact of enactment of this section during the 12-month period beginning with the fifth year of the 5-year period described in subsection (d). Not later than the end of such 12-month period the Comptroller General shall submit to Congress a report on such study and shall include in the report such recommendations on the extension of this section (and changes that should be made in making such extension) as the Comptroller General deems appropriate.

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

(1) ANTITRUST LAWS.—The term ''antitrust laws''—

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

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

(2) HEALTH PLAN AND RELATED TERMS.—

(A) IN GENERAL.—The term ''health plan'' means a group health plan or a health insurance issuer that is offering health insurance coverage.

(B) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms ''health insurance coverage'' and ''health insurance issuer'' have the meanings given such terms under paragraphs (1) and (2), respectively, of section 733(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)).

(C) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given that term in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

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

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

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

is deemed to be doing business in that secondary State.

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

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

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

''(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

''(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

''(B) to pay other obligations in the normal course of business.

''(7) COVERED LAWS.—

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

''(i) individual health insurance coverage issued by a health insurance issuer;

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

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

''(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

"(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

"(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

"(8) STATE.—The term 'State' means only the 50 States and the District of Columbia.

"(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

"(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

"(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

"(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

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

"(E) Refusing to pay claims without conducting a reasonable investigation.

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

"(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

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

''(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

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

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

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

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

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

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

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

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

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

''SEC. 2796. APPLICATION OF LAW.

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

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rat-

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

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

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

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

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

''(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

''(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

''(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

''(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

''(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

''(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

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

"(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.".

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

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

''(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

''(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

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

''(B) from raising premium rates for all policy holders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

''(iii) are not obtainable by all individuals to whom coverage is offered;

''(D) from reinstating lapsed coverage; or

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

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

''(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

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

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

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

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

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

''(B) a qualified loss reserve specialist.

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

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

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

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

''(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

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

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

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

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

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

of State laws generally applicable to persons or corporations.

''(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

"SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

''A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless——

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

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

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

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

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

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

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

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

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

''(I) a non-affiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

"(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

"(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

"(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

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

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 2799. ENFORCEMENT.

"(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

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

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

"(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.".

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

(c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

(d) SEVERABILITY.—If any provision of the section or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder

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

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

SEC. 401. SHORT TITLE.

This title may be cited as the ''Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2007''.

SEC. 402. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance

industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

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

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

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

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

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

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 403. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the

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

(1) upon proof of fraud;

(2) intentional concealment; or

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

SEC. 404. COMPENSATING PATIENT INJURY.

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

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

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

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

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

person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 405. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

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

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

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

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 406. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source bene-

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

SEC. 407. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a mo-

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

(1) whether punitive damages are to be awarded and the amount of such award; and

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

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

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

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

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

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Admin-

istration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

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

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is causally related to the harm which the claimant allegedly suffered; or

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.

SEC. 408. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

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

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 409. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

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

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

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

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses

of any kind or nature. The term ''compensatory damages'' includes economic damages and non-economic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or

pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

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

care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

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

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

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

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

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

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office

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

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 410. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

under this title) will apply to such aspect of such action.

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

SEC. 411. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

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

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

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

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

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

(1) any State law (whether effective before, on, or after the date of the enactment of this title) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 4(a); or

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

SEC. 412. APPLICABILITY; EFFECTIVE DATE.

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

SEC. 413. SENSE OF CONGRESS.

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

SEC. 414. STATE GRANTS TO CREATE ADMINISTRATIVE HEALTH CARE TRIBUNALS.

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

"SEC. 399R. STATE GRANTS TO CREATE ADMINISTRATIVE HEALTH CARE TRIBUNALS.

''(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of administrative health care tribunals that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers.

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

''(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute before an administrative health care tribunal operated under such grant from obtaining legal representation during any review by the expert panel under subsection (d), the administrative health care tribunal under subsection (e), or a State court under subsection (f).

''(d) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

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

''(2) COMPOSITION.—

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

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

''(B) LICENSURE AND EXPERTISE.—Each physician or health care professional appointed to an expert panel under subparagraph (A) shall—

''(i) be appropriately credentialed or licensed in 1 or more States to deliver health care services; and

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

''(C) INDEPENDENCE.—

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

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

''(II) not otherwise have a conflict of interest with such a party.

"(ii) EXCEPTION.—Nothing in clause (i) shall be construed to prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

"(D) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

"(i) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

"(I) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(II) by a health care professional other than a physician, at least

two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

''(ii) PRACTICING DEFINED.—In this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

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

''(3) DETERMINATION.—After a review under paragraph (1), an expert panel shall make a determination as to the liability of the parties involved and compensation.

''(4) ACCEPTANCE.—If the parties to a dispute before an expert panel under this subsection accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers involved.

''(5) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel's determination, the matter shall be referred to an administrative health care tribunal created pursuant to this section.

''(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(1) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subsection (d), the parties shall have the right to request a hearing concerning the liability or compensation involved by an administrative health care tribunal established by the State involved.

''(2) REQUIREMENTS.—In establishing an administrative health care tribunal under this section, a State shall—

''(A) ensure that such tribunals are presided over by special judges with health care expertise;

''(B) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

''(C) establish gross negligence as the legal standard for the tribunal;

''(D) allow the admission into evidence of the recommendation made by the expert panel under subsection (d); and

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

''(f) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

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

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

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

''(3) ADMISSIBILITY.—The determinations of the expert panel and the administrative health care tribunal pursuant to subsections (d) and (e) with respect to a State court proceeding under paragraph (1) shall be admissible into evidence in any such State court proceeding.

''(g) DEFINITION.—In this section, the term 'health care provider' has the meaning given such term for purposes of part A of title VII.

''(h) FUNDING.—

''(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of Federal payments made to the State under section 1903(a) of the Social Security Act or section 1939(b)of such Act (in the case of fiscal year 2010 or any fiscal year thereafter) for the first fiscal year for which such grant is awarded shall be increased by an amount equal to 1 percent of of the total amount of such payments made to the State for the preceding fiscal year under such 1903(a) or 1939(b) (as applicable) for purposes of carrying out this section.

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

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).''.

TITLE V—TAX CREDIT FOR HEALTH INFORMATION TECHNOLOGY

SEC. 501. PURCHASE OF QUALIFIED HEALTH CARE INFORMATION TECHNOLOGY.

(a) IN GENERAL.—Section 179 of the Internal Revenue Code of 1986 (relating to election to expense certain depreciable assets) is amended by adding at the end the following new subsection:

''(e) HEALTH CARE INFORMATION TECHNOLOGY.—

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

''(A) subsection (b)(1) shall be applied by substituting '$300,000' for '$100,000',

''(B) subsection (b)(2) shall be applied by substituting '$600,000' for '$400,000', and

"(C) subsection (b)(5)(A) shall be applied by substituting '$300,000 and $600,000' for '$100,000 and $400,000'.

"(2) DEFINITIONS.—For purposes of this subsection—

"(A) QUALIFIED HEALTH CARE INFORMATION TECHNOLOGY.—The term 'qualified health care information technology' means section 179 property which is used primarily for the electronic creation, maintenance, and exchange of medical care information to improve the quality or efficiency of medical care.

"(B) MEDICAL CARE PROVIDER.—The term 'medical care provider' means any person engaged in the trade or business of providing medical care.

"(C) MEDICAL CARE.—The term 'medical care' has the meaning given such term by section 213(d).".

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

SEC. 502. TELECOMMUNICATIONS CREDIT FOR QUALIFIED MEDICAL CARE PROVIDERS.

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

"SEC. 45N. TELECOMMUNICATIONS CREDIT FOR QUALIFIED MEDICAL CARE PROVIDERS.

''(a) GENERAL RULE.—For purposes of section 38, in the case of a qualified medical care provider, the telecommunications credit determined under this section for a taxable year is an amount equal to 50 percent of the applicable telecommunications charges paid or incurred by such provider during the taxable year.

''(b) DOLLAR LIMITATION.—In the case of a qualified medical care provider, the credit determined under subsection (a) for a taxable year shall not exceed $12,500.

''(c) DEFINITIONS.—For purposes of this section—

''(1) APPLICABLE TELECOMMUNICATIONS CHARGES.—The term 'applicable telecommunications charges' means expenses paid or incurred for the purpose of installing or maintaining a communications network that supports interoperability of electronic medical record systems.

''(2) QUALIFIED MEDICAL CARE PROVIDER.—The term 'qualified medical care provider' means

any person engaged in the trade or business of providing medical care (as defined in section 213(d)) who has purchased qualified health care information technology (as defined in section 179(e)).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 38(b) of such Code is amended by striking ''plus'' at the end of paragraph (25), by striking the period at the end of paragraph (26) and inserting '', plus'', and by adding at the end the following new paragraph:

''(27) the telecommunications credit determined under section 45N.''.

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

''Sec. 45N. Telecommunications credit for qualified medical care providers.''.

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

SEC. 503. DEVELOPMENT OF HEALTH CARE INFORMATION TECHNOLOGY STANDARDS.

Not later than 5 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall develop standards for health information technology, including for qualified health care information

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

TITLE VI—MEDICAL LIABILITY REFORMS

SEC. 601. CONSTITUTIONAL AUTHORITY.

The constitutional authority upon which this title rests is the power of the Congress to provide for the general welfare, to regulate commerce, and to make all laws which shall be necessary and proper for carrying into execution Federal powers, as enumerated in section 8 of article I of the Constitution of the United States.

SEC. 602. PROTECTION AGAINST LEGAL LIABILITY FOR EMERGENCY AND RELATED SERVICES FURNISHED TO ANY INDIVIDUAL.

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

(1) in paragraph (4), by striking ''An entity'' and inserting in lieu thereof ''Subject to paragraph (6), an entity''; and

(2) by adding at the end the following:

''(6)(A) For purposes of this section—

''(i) an entity described in subparagraph (B) shall be considered to be an entity described in paragraph (4); and

''(ii) the provisions of this section shall apply to an entity described in subparagraph (B) in the same manner as such provisions apply to an entity described in paragraph (4), except that—

''(I) notwithstanding paragraph (1)(B), the deeming of any entity described in subparagraph (B), or of an officer, governing board member, employee, or contractor of such an entity, to be an employee of the Public Health Service for purposes of this section shall apply only with respect to items and services that are furnished to an individual pursuant to section 1867 of the Social Security Act and to post-stabilization services (as defined in subparagraph (C)) furnished to such an individual;

''(II) nothing in paragraph (1)(D) shall be construed as preventing a physician or physician group described in subparagraph (B)(ii) from making the application referred to in such paragraph or as conditioning the deeming of a physician or physician group that makes such an application upon receipt by the Secretary of an application from the hospital or emergency department that employs or contracts with the physician or group;

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

"(IV) paragraph (5) shall not apply to a physician or physician group described in subparagraph (B)(ii);

"(V) the Attorney General, in consultation with the Secretary, shall make separate estimates under subsection (k)(1) with respect to entities described in subparagraph (B) and entities described in paragraph (4) (other than those described in subparagraph (B)), and the Secretary shall establish separate funds under subsection (k)(2) with respect to such groups of entities, and any appropriations under this subsection for entities described in subparagraph (B) shall be separate from the amounts authorized by subsection (k)(2);

"(VI) notwithstanding subsection (k)(2), the amount of the fund established by the Secretary under such subsection with respect to entities described in subparagraph (B) may exceed a total of $10,000,000 for a fiscal year; and

''(VII) subsection (m) shall not apply to entities described in subparagraph (B).

''(B) An entity described in this subparagraph is—

''(i) a hospital or an emergency department to which section 1867 of the Social Security Act applies; and

''(ii) a physician or physician group that is employed by, or under contract with, such hospital or department to furnish items and services to individuals under such section, including so-called 'on call physicians' .

''(C) For purposes of this paragraph, the term 'post-stabilization services' means, with respect to an individual who has been treated by an entity described in subparagraph (B) for purposes of complying with section 1867 of the Social Security Act, services that are—

''(i) related to the condition that was so treated; and

''(ii) provided after the individual is stabilized in order to maintain the stabilized condition or to improve or resolve the individual's condition.

''(D)(i) Nothing in this paragraph (or in any other provision of this section as such provision applies to entities described in subparagraph (B) by operation of subparagraph (A)) shall be construed as authorizing or re-

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

''(ii) The Secretary shall limit the total amount of payments under this paragraph for a fiscal year to the total amount appropriated in advance by appropriation Acts for such purpose for such fiscal year. If the total amount of payments that would otherwise be made under this paragraph for a fiscal year exceeds such total amount appropriated, the Secretary shall take such steps as may be necessary to ensure that the total amount of payments under this paragraph for such fiscal year does not exceed such total amount appropriated.''.

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.

(a) IN GENERAL.—Section 166 of the Internal Revenue Code of 1986 (relating to bad debts) is amended by

redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f) BAD DEBT TREATMENT FOR DOCTORS TO PARTIALLY OFFSET COST OF PROVIDING UNCOMPENSATED CARE REQUIRED TO BE PROVIDED.—

"(1) AMOUNT OF DEDUCTION.—

"(A) IN GENERAL.—For purposes of subsection (a), the basis for determining the amount of any deduction for an eligible EMTALA debt shall be treated as being equal to the Medicare payment amount.

"(B) MEDICARE PAYMENT AMOUNT.—For purposes of subparagraph (A), the Medicare payment amount with respect to an eligible EMTALA debt is the fee schedule amount established under section 1848 of the Social Security Act for the physicians' service (to which such debt relates) as if the service were provided to an individual enrolled under part B of title XVIIII of such Act.

"(2) ELIGIBLE EMTALA DEBT.—For purposes of this section, the term 'eligible EMTALA debt' means any debt if—

"(A) such debt arose as a result of physicians' services—

''(i) which were performed in an EMTALA hospital by a board-certified physician (whether as part of medical screening or necessary stabilizing treatment and whether as an emergency department physician, as an on-call physician, or otherwise), and

''(ii) which were required to be provided under section 1867 of the Social Security Act (42 U.S.C. 1395dd), and

''(B) such debt is owed—

''(i) to such physician, or

''(ii) to an entity if—

''(I) such entity is a corporation and the sole shareholder of such corporation is such physician, or

''(II) such entity is a partnership and any deduction under this subsection with respect to such debt is allocated to such physician or to an entity described in subclause (I).

''(3) BOARD-CERTIFIED PHYSICIAN.—For purposes of this subsection, the term 'board-certified physician' means any physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C.

1395x(r)) who is certified by the American Board of Emergency Medicine or other appropriate medical specialty board for the specialty in which the physician practices, or who meets comparable requirements, as identified by the Secretary of the Treasury in consultation with Secretary of Health and Human Services.

''(4) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) EMTALA HOSPITAL.—The term 'EMTALA hospital' means any hospital having a hospital emergency department which is required to comply with section 1867 of the Social Security Act (42 U.S.C. 1395dd) (relating to examination and treatment for emergency medical conditions and women in labor).

''(B) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to debts arising from services performed in taxable years beginning after the date of the enactment of this Act.

TITLE VIII—ADDITIONAL CHANGES

SEC. 801. APPLICATION OF SECTION 1115 WAIVERS BY OTHER STATES.

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

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

SEC. 802. HIPAA TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the HIPAA regulations and their implementation. In this section, the term ''HIPAA regulations'' refers to the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–1 note).

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

the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 2 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of HIPAA regulations;

(2) 9 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopaedic surgery, neurosurgery, general surgery with expertise in trauma, internal medicine, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall be non-physician representatives from private medical practices with significant patient volume;

(4) 2 shall represent patients;

(5) 2 shall be staff involved in HIPAA regulations investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(6) 1 shall be from a State survey office involved in HIPAA regulations investigations and 1 shall be from a peer review organization, both of

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

In selecting members described in paragraphs (1) through (4), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review HIPAA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals, medical practices, outpatient services and physicians;

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

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public; and

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

(d) ADMINISTRATIVE MATTERS.—

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

person of the Advisory Group for the life of the Advisory Group.

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

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

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

SEC. 803. MEDICARE PHYSICIAN PAYMENT UPDATE REFORM.

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

(1) in paragraph (1)(A), by inserting ''and before 2008'' after ''beginning with 2001'';

(2) in paragraph (1)(A), by inserting before the period at the end the following: '', and for years beginning with 2008, multiplied by the update established under paragraph (7) applicable to the year involved''; and

(3) in paragraph (4)—

(A) in the heading by striking ''YEARS BEGINNING WITH 2001'' and inserting ''2001, 2002, AND 2003''; and

(B) in subparagraph (A), by inserting ''and ending with 2003'' after ''beginning with 2001''; and

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

''(8) UPDATE BEGINNING WITH 2008.—The update to the single conversion factor established in paragraph (1)(C) for 2008 and each succeeding year shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.''.

(b) ENDING APPLICATION OF SUSTAINABLE GROWTH RATE (SGR).—Section 1848(f)(1)(B) of such Act (42 U.S.C. 1395w–4(f)(1)(B)) is amended by inserting ''(and before 2007)'' after ''each succeeding year''.

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

SEC. 804. REMOVING LIMITATIONS ON BALANCE BILLING WITH BENEFICIARY NOTICE.

(a) IN GENERAL.—Section 1848(g) of the Social Security Act (42 U.S.C. 1395w–4(g)) is amended—

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

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

"(D) EXCEPTION.—Subparagraph (A) shall not apply with respect to physicians' services furnished in a month to an individual if the individual furnishing such services provides the advance notice of such non-participation and non-acceptance of assignment under paragraph (8) and (for services furnished on or after January 1, 2008) submits information in accordance with subsection (k)(4)."; and

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

"(8) NOTICE OF NON-PARTICIPATION AND NON-ACCEPTANCE OF ASSIGNMENT.—For purposes of paragraph (1)(D), the advance notice of non-participation and non-acceptance of assignment shall be, with respect to an item or service furnished under this part by (or under the supervision of) a physician, a notice (that may be in the form of a posting in a conspicuous place in a physician's office or on patient information forms) that is posted or other-

wise furnished in a manner so as to inform the individual receiving the item or service that—

''(A) the physician furnishing (or supervising the furnishing of) the items or service is not a participating physician and does not accept assignment with respect to the service; and

''(B) because of such non-acceptance, in the case of physicians' services furnished in a month to an individual, the charge imposed is not limited and may exceed the limiting charge described in paragraph (2).''.

(b) CONFORMING AMENDMENT TO PRIVATE CONTRACT PROVISIONS.—Section 1802 of such Act (42 U.S.C. 1395a) is amended by adding at the end the following new paragraph:

''(6) EXCEPTION.—The previous provisions of this subsection shall not apply to physicians' services furnished in a month to an individual if the advance notice described in section 1848(g)(8) has been provided and (for services furnished on or after January 1, 2008) the physician furnishing the services submits information in accordance with section 1848(k)(4).''.

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

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

''(8) The previous provisions of this subsection, insofar as they limit the charges that a participating physician may impose, shall not apply to physicians' services furnished in a month to an individual if the advance notice described in section 1848(g)(8) has been provided and (for services furnished on or after January 1, 2008) the physician furnishing the services submits information in accordance with section 1848(k)(4).''.

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

SEC. 805. ELECTION OF TAX CREDIT INSTEAD OF ALTERNATIVE GOVERNMENT BENEFITS.

(a) IN GENERAL.—Notwithstanding any other provision of law, an individual who is otherwise eligible for benefits under a Federal health program (as defined in subsection (c)) may elect, in a form and manner specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury, to receive a tax credit described in section 36 of the Internal Revenue Code of 1986 (which may be used for the purpose of health insurance coverage) in lieu of receiving any benefits under such program.

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

(c) FEDERAL HEALTH PROGRAM DEFINED.—For purposes of this section, the term ''Federal health program'' means any of the following:

(1) MEDICARE.—The medicare program under part A of title XVIII of the Social Security Act, including any benefits under any other part of such title.

(2) MEDICAID.—The Medicaid program under title XIX of such Act (including such a program operating under a Statewide waiver under section 1115 of such Act).

(3) SCHIP.—The State children's health insurance program under title XXI of such Act.

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

(5) VETERANS BENEFITS.—Coverage for benefits under chapter 17 of title 38, United States Code.

SEC. 806. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.

(a) IN GENERAL.—Section 1802 of the Social Security Act (42 U.S.C. 1395a) is amended by striking subsection (b) and inserting the following:

''(b) CLARIFICATION OF USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.—

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

''(A) the services are covered under a private contract that is between the beneficiary and the physician or practitioner and meets the requirements of paragraph (2);

''(B) under the private contract no claim for payment for services covered under the contract is to be submitted (and no payment made) under part A or B under a contract under section 1876, or under a Medicare Advantage plan (other than an MSA plan); and

"(C)(i) the Secretary has been provided with the minimum information necessary to avoid any payment under part A or B for services covered under the contract, or

"(ii) in the case of an individual enrolled under a contract under section 1876 or a Medicare Advantage plan (other than an MSA plan) under part C, the eligible organization under the contract or the Medicare Advantage organization offering the plan has been provided the minimum information necessary to avoid any payment under such contract or plan for services covered under the contract.

"(2) REQUIREMENTS FOR PRIVATE CONTRACTS.—The requirements in this paragraph for a private contract between a medicare beneficiary and a physician or health care practitioner are as follows:

"(A) GENERAL FORM OF CONTRACT.—The contract is in writing and is signed by the medicare beneficiary.

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

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

''(C) SCOPE OF SERVICES.—The contract identifies the medicare covered professional services and the period (if any) to be covered under the contract, but does not cover any services furnished—

''(i) before the contract is entered into; or

''(ii) for the treatment of an emergency medical condition (as defined in section 1867(e)(1)(A)), unless the contract was entered into before the onset of the emergency medical condition.

''(D) CLEAR DISCLOSURE OF TERMS.—The contract clearly indicates that by signing the contract the medicare beneficiary—

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

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

''(ii) agrees to be responsible, whether through insurance or otherwise, for payment for such services and understands that no reimbursement will be provided under such part, contract, or plan for such services;

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

''(iv) acknowledges that medicare supplemental policies under section 1882 do not, and other supplemental health plans and policies may elect not to, make payments for such services because payment is not made under this title; and

''(v) acknowledges that the beneficiary has the right to have such services provided by (or under the supervision of) other physicians or health care practitioners for whom payment would be made under such part, contract, or plan.

Such contract shall also clearly indicate whether the physician or practitioner involved is excluded from participation under this title.

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

''(4) NO REQUIREMENTS FOR SERVICES FURNISHED TO MSA PLAN ENROLLEES.—The requirements of paragraphs (1) and (2) do not apply to any contract or arrangement for the provision of services to a medicare beneficiary enrolled in an MSA plan under part C.

''(5) DEFINITIONS.—In this subsection:

''(A) HEALTH CARE PRACTITIONER.—The term 'health care practitioner' means a practitioner described in section 1842(b)(18)(C).

''(B) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is enrolled under part B.

''(C) MEDICARE COVERED PROFESSIONAL SERVICES.—The term 'medicare covered professional services' means—

"(i) physicians' services (as defined in section 1861(q), and including services described in section 1861(s)(2)(A)), and

"(ii) professional services of health care practitioners, including services described in section 1842(b)(18)(D),

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

"(D) MEDICARE ADVANTAGE PLAN; MSA PLAN.—The terms 'Medicare Advantage plan' and 'MSA plan' have the meanings given the terms 'Medicare+Choice plan' and 'MSA plan' in section 1859.

"(E) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r).".

(b) CONFORMING AMENDMENTS CLARIFYING EXEMPTION FROM LIMITING CHARGE AND FROM REQUIREMENT FOR SUBMISSION OF CLAIMS.—Section 1848(g) of the Social Security Act (42 U.S.C. 1395w–4(g)) is amended—

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

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

(3) in paragraph (4)(A), by striking ''For'' and inserting ''Subject to paragraph (8), for''; and

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

''(8) EXEMPTION FROM REQUIREMENTS FOR SERVICES FURNISHED UNDER PRIVATE CONTRACTS.—

''(A) IN GENERAL.—Pursuant to section 1802(b)(1), paragraphs (1), (3), and (4) do not apply with respect to physicians' services (and services described in section 1861(s)(2)(A)) furnished to an individual by (or under the supervision of) a physician if the conditions described in section 1802(b)(1) are met with respect to the services.

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

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

''(C) APPLICATION TO ENROLLEES IN OTHER PLANS.—Subject to subparagraph (B) and section 1852(k)(2), the provisions of subparagraph (A) shall apply in the case of an individual enrolled under a contract under section 1876 or under a Medicare Advantage plan (other than an MSA plan) under part C, in the same manner as they apply to individuals not enrolled under such a contract or plan.''.

(c) CONFORMING AMENDMENTS.—

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

''(E) The provisions of section 1848(g)(8) shall apply with respect to exemption from limitations on charges and from billing requirements for services of health care practitioners described in this paragraph in the same manner as such provisions apply to exemption from the requirements referred to in section 1848(g)(8)(A) for physicians' services.''.

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

''(other than under an MSA plan)'' after ''Medicare+Choice organization under part C''.

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

SEC. 807. EMTALA TECHNICAL ADVISORY GROUP.

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

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

''(g) SECRETARIAL RESPONSE TO RECOMMENDATIONS.—The Secretary shall review the recommendations made to the Secretary by the Advisory Group and shall submit to Congress a report that contains a description of any actions the Secretary intends to take in response to such recommendations and problems identified by the Advisory Group with regard to the EMTALA regulations and their application.''.

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

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

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

(2) in subsection (f) of section 729 (as so redesignated), by striking ''is authorized to be appropriated to be appropriated $10,000,000 for each of the fiscal years 1994 through 1996'' and inserting ''are authorized to be appropriated such sums as may be necessary for fiscal year 2008 and each fiscal year thereafter''.

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

''Subpart III—Federally-Supported Student Loan Funds for Certain Medical Students

''SEC. 730. SCHOOL LOAN FUNDS FOR CERTAIN MEDICAL STUDENTS.

''(a) FUND AGREEMENTS.—For the purpose described in subsection (b), the Secretary is authorized to enter into an agreement for the establishment and operation of a student loan fund with any public or nonprofit school of medicine or osteopathic medicine.

''(b) PURPOSE.—The purpose of this subpart is to provide for loans to medical students who would be eligible for a loan under subpart II, except for the student's decision to enter a residency training program in a field other than primary health care.

''(c) COMMENCEMENT OF REPAYMENT PERIOD.—The repayment period for a loan under this section shall not begin before the end of any period during which the student is participating in an internship, residency, or fellowship training program directly related to the field of medicine which the student agrees to enter pursuant to subsection (d).

''(d) REQUIREMENTS FOR STUDENTS.—Each agreement under this section for the establishment of a student loan fund shall provide that the school of medicine or osteopathic medicine will make a loan to a student from such fund only if the student agrees—

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

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

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

''(f) APPLICABILITY OF OTHER PROVISIONS.—Except as inconsistent with this section, the provisions of subpart II shall apply to the program of student loan funds established under this section to the same extent and in the same manner as such provisions apply to the program of student loan funds established under subpart II.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2008 and each fiscal year thereafter.''.

SEC. 809. ESTABLISHMENT OF PERFORMANCE-BASED QUALITY MEASURES.

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

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

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