

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

A BILL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 with other financial responsibilities from attending
2 medical school.

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

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

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

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

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

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

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

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

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

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

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

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

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH
INSURANCE COVERAGE

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

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

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

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

TITLE II—QUALITY HEALTH-CARE PROFESSIONALS COALITION
 ACT

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

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

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

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

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

TITLE V—TAX CREDIT FOR HEALTH INFORMATION
 TECHNOLOGY

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

TITLE VI—MEDICAL LIABILITY REFORMS

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

TITLE VII—TAX DEDUCTION FOR UNCOMPENSATED CARE IN
 EMERGENCY ROOMS

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

TITLE VIII—ADDITIONAL CHANGES

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

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

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

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

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

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

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

19 “(b) LIMITATIONS.—

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

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

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

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

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

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

13 “(3) CREDIT PERCENTAGE.—

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

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

24 “(i) \$20,000,

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

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

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

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

14 “(A) such dollar amount, multiplied by

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

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

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

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

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

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

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

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

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

12 “(2) any dependent of the taxpayer.

13 “(e) QUALIFIED HEALTH INSURANCE.—

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

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

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

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

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

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

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

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

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

19 “(ii) Guaranteed renewability.

20 “(iii) Premium ratings.

21 “(iv) Risk-spreading.

22 “(v) Consumer disclosures.

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

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

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

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

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

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

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

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

19 “(g) SPECIAL RULES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (c) INFORMATION REPORTING.—

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

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

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

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

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

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

18 “(2) contains—

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

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

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

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

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

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

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

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

20 (2) ASSESSABLE PENALTIES.—

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

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

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

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

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

16 (d) CLERICAL AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

23 “(c) SPECIAL RULES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (c) LIMITATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (2) HEALTH PLAN AND RELATED TERMS.—

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

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

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

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

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

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

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

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

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

3 **“SEC. 2795. DEFINITIONS.**

4 “In this part:

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

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

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

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

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

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

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

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

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

6 “(7) COVERED LAWS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 “(D) from reinstating lapsed coverage; or

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

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

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

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

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

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

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

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

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

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

14 “(B) a qualified loss reserve specialist.

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

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

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

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

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

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

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

16 “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(3) INDEPENDENCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 **“SEC. 2799. ENFORCEMENT.**

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

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

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

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

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

25 (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (a) FINDINGS.—

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

24 (2) EFFECT ON INTERSTATE COMMERCE.—

25 Congress finds that the health care and insurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (1) upon proof of fraud;

6 (2) intentional concealment; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (1) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **SEC. 409. DEFINITIONS.**

24 In this title:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (a) VACCINE INJURY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 “(2) COMPOSITION.—

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

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

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

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

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

15 “(C) INDEPENDENCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(h) FUNDING.—

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

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

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

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

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

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

17 “(e) HEALTH CARE INFORMATION TECHNOLOGY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 “(1) AMOUNT OF DEDUCTION.—

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

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

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

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

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

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

11 “(B) such debt is owed—

12 “(i) to such physician, or

13 “(ii) to an entity if—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (4) 2 shall represent patients;

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

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

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

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

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

9 (1) shall review HIPAA regulations;

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

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

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

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

23 (d) ADMINISTRATIVE MATTERS.—

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

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

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

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

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

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

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

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

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

1 (3) in paragraph (4)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (c) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

