

113TH CONGRESS  
1ST SESSION

# H. R. 2165

To amend the Public Health Service Act to provide individual and group market reforms to protect health insurance consumers, to make such reforms and protections contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

MAY 23, 2013

Mr. HECK of Nevada (for himself and Mr. FITZPATRICK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Public Health Service Act to provide individual and group market reforms to protect health insurance consumers, to make such reforms and protections contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, 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,*

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

2 (a) **SHORT TITLE.**—This Act may be cited as the  
 3 “Ensuring Quality Health Care for All Americans Act of  
 4 2013”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Effective date contingent on repeal of PPACA.
- Sec. 3. Prohibiting discrimination based on health status.
- Sec. 4. Guaranteed renewability of coverage.
- Sec. 5. Prohibition of preexisting condition exclusions and other discrimination based on health status.
- Sec. 6. No lifetime or annual limits.
- Sec. 7. Prohibition on rescissions.
- Sec. 8. Extension of dependent coverage.
- Sec. 9. Application of group market reforms to ERISA and the Internal Revenue Code of 1986.
- Sec. 10. Catastrophic plan.
- Sec. 11. Grants for health insurance risk adjustment mechanisms.
- Sec. 12. Liability protections for health care providers.

7 **SEC. 2. EFFECTIVE DATE CONTINGENT ON REPEAL OF**  
 8 **PPACA.**

9 (a) **IN GENERAL.**—This Act and the amendments  
 10 made by this Act shall take effect upon the enactment of  
 11 PPACA repeal legislation described in subsection (b) and  
 12 this Act and the amendments made by this Act shall have  
 13 no force or effect if such PPACA repeal legislation is not  
 14 enacted.

15 (b) **PPACA REPEAL LEGISLATION DESCRIBED.**—  
 16 For purposes of subsection (a), PPACA repeal legislation  
 17 described in this subsection is legislation that—

18 (1) repeals Public Law 111–148, and restores  
 19 or revives the provisions of law amended or repealed,

1       respectively, by such Act as if such Act had not been  
2       enacted and without further amendment to such  
3       provisions of law; and

4             (2) repeals title I and subtitle B of title II of  
5       the Health Care and Education Reconciliation Act of  
6       2010 (Public Law 111–152), and restores or revives  
7       the provisions of law amended or repealed, respec-  
8       tively, by such title or subtitle, respectively, as if  
9       such title and subtitle had not been enacted and  
10      without further amendment to such provisions of  
11      law.

12 **SEC. 3. PROHIBITING DISCRIMINATION BASED ON HEALTH**  
13                                   **STATUS.**

14       (a) **GROUP MARKET.**—Subpart 3 of part A of title  
15 **XXVII** of the Public Health Service Act is amended by  
16 striking section 2711 of such Act (42 U.S.C. 300gg–11)  
17 and inserting the following:

18 **“SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE.**

19       “(a) **GUARANTEED ISSUANCE OF COVERAGE IN THE**  
20 **GROUP MARKET.**—

21             “(1) **IN GENERAL.**—Subject to subsections (b)  
22 through (e), each health insurance issuer that offers  
23 health insurance coverage in the group market in a  
24 State shall accept every employer and every indi-

1       vidual in a group in the State that applies for such  
2       coverage.

3               “(2) SPECIAL RULE FOR ASSOCIATIONS.—An  
4       association shall be treated as an employer for pur-  
5       poses of this section if such association seeks to pro-  
6       vide group health insurance coverage to not less  
7       than 200 qualified individuals.

8       “(b) ENROLLMENT.—

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

13              “(2) ESTABLISHMENT.—A health insurance  
14      issuer described in subsection (a) shall, in accord-  
15      ance with the regulations promulgated under para-  
16      graph (3), establish special enrollment periods for  
17      qualifying events (as such term is defined in section  
18      603 of the Employee Retirement Income Security  
19      Act of 1974).

20              “(3) SPECIAL RULES FOR ASSOCIATIONS.—

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

23                              “(i) the term ‘covered employee’ in  
24                              section 603 of the Employee Retirement  
25                              Income Security Act of 1974 shall include

1 a qualified individual (as such term is de-  
2 fined in section 2701(d)(2)(D));

3 “(ii) the term ‘employer’ shall include  
4 an association (as such term is defined in  
5 section 2701(d)(2)(A)); and

6 “(iii) the term ‘termination (other  
7 than by reason of such employee’s gross  
8 misconduct), or reduction of hours, of the  
9 covered employee’s employment’ shall in-  
10 clude the termination of membership to the  
11 association.

12 “(B) ENROLLMENT.—With respect to  
13 health insurance coverage provided to an asso-  
14 ciation under subsection (a)(2), a health insur-  
15 ance issuer shall permit a qualified individual  
16 who is eligible, but not enrolled (or a dependent  
17 of such individual if the dependent is eligible,  
18 but not enrolled) for such coverage to enroll for  
19 coverage under the terms of such coverage  
20 when any one of the following events occur:

21 “(i) NEW MEMBERS AND EMPLOY-  
22 EES.—A qualified individual, and any de-  
23 pendent of such individual, may enroll dur-  
24 ing the 30-day period following the end of  
25 the period described under section

1                   2701(d)(2)(D) that applies to such indi-  
2                   vidual.

3                   “(ii) ANNUAL ENROLLMENT.—A  
4                   qualified individual, and any dependent of  
5                   such individual, may enroll during the an-  
6                   nual enrollment period established under  
7                   the terms of the coverage

8                   “(C) TERMINATION OF ENROLLMENT.—  
9                   With respect to group health insurance cov-  
10                  erage provided by an association, a qualified in-  
11                  dividual or dependent who terminates enroll-  
12                  ment in such coverage may only re-enroll in  
13                  such coverage during the annual enrollment pe-  
14                  riod described under subparagraph (B)(ii).

15                  “(D) DEFINITIONS.—For purposes of this  
16                  section, the terms ‘association’ and ‘qualified  
17                  individual’ have the meaning given such terms  
18                  in section 2701(d)(2).

19                  “(4) REGULATIONS.—The Secretary shall pro-  
20                  mulgate regulations with respect to enrollment peri-  
21                  ods under this subsection.

22                  “(c) SPECIAL RULES FOR NETWORK PLANS.—

23                  “(1) IN GENERAL.—In the case of a health in-  
24                  surance issuer that offers health insurance coverage

1 in the group market in a State through a network  
2 plan, the issuer may—

3 “(A) limit the employers that may apply  
4 for such coverage to those with eligible individ-  
5 uals who live, work, or reside in the service area  
6 for such network plan; and

7 “(B) within the service area of such plan,  
8 deny such coverage to such employers if the  
9 issuer has demonstrated, if required, to the ap-  
10 plicable State authority that—

11 “(i) it will not have the capacity to de-  
12 liver services adequately to enrollees of any  
13 additional groups because of its obligations  
14 to existing group contract holders and en-  
15 rollees; and

16 “(ii) it is applying this paragraph uni-  
17 formly to all employers without regard  
18 to—

19 “(I) the claims experience of  
20 those employers and their employees  
21 (and their dependents); or

22 “(II) any health-status-related  
23 factor relating to such employees and  
24 dependents.

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

7           “(d) APPLICATION OF FINANCIAL CAPACITY LIM-  
8           ITS.—

9           “(1) IN GENERAL.—A health insurance issuer  
10          may deny health insurance coverage in the group if  
11          the issuer has demonstrated, if required, to the ap-  
12          plicable State authority that—

13                 “(A) it does not have the financial reserves  
14                 necessary to underwrite additional coverage;  
15                 and

16                 “(B) it is applying this paragraph uni-  
17                 formly to all employers and individuals in the  
18                 group market in the State—

19                         “(i) in a manner that is consistent  
20                         with applicable State law; and

21                         “(ii) without regard to—

22                                 “(I) the claims experience of  
23                                 those individuals, employers, and their  
24                                 employees (and their dependents); or



1                   “(II) any health-status-related  
2                   factor relating to such individuals,  
3                   employees, and dependents.

4                   “(2) 180-DAY SUSPENSION UPON DENIAL OF  
5                   COVERAGE.—A health insurance issuer upon denying  
6                   health insurance coverage in connection with group  
7                   health plans in accordance with paragraph (1) in a  
8                   State may not offer coverage in connection with  
9                   group health plans in the group market in the State  
10                  for a period of 180 days after the date such cov-  
11                  erage is denied or until the issuer has demonstrated  
12                  to the applicable State authority, if required under  
13                  applicable State law, that the issuer has sufficient fi-  
14                  nancial reserves to underwrite additional coverage,  
15                  whichever is later. An applicable State authority  
16                  may provide for the application of this subsection on  
17                  a service-area-specific basis.”.

18                  (b) INDIVIDUAL MARKET.—Subpart 1 of part B of  
19                  title XXVII of the Public Health Service Act is amended  
20                  by striking section 2741 of such Act (42 U.S.C. 300gg–  
21                  41) and inserting the following:

22                  **“SEC. 2741. GUARANTEED AVAILABILITY OF COVERAGE.**

23                  “The provisions of section 2711 (other than sub-  
24                  section (a)(2) and subsection (b)(3)) shall apply to health  
25                  insurance coverage offered to individuals by a health in-

1 surance issuer in the individual market in the same man-  
2 ner as such provisions apply to health insurance coverage  
3 offered to employers by a health insurance issuer in con-  
4 nection with health insurance coverage in the group mar-  
5 ket. For purposes of this section, the Secretary shall treat  
6 any reference of the word ‘employer’ in such section as  
7 a reference to the term ‘individual’.”.

8 **SEC. 4. GUARANTEED RENEWABILITY OF COVERAGE.**

9 Section 2712 of the Public Health Service Act (42  
10 U.S.C. 300gg–12) is amended—

11 (1) in subsection (a)—

12 (A) by inserting “, including coverage of-  
13 fered” before “in connection with a group  
14 health plan”; and

15 (B) by inserting “employer or other” be-  
16 fore “plan sponsor of the plan”;

17 (2) in subsection (b)—

18 (A) in the matter before paragraph (1), by  
19 striking “health insurance coverage in connec-  
20 tion with a group health plan in the small or  
21 large group market” and insert “such health in-  
22 surance coverage”; and

23 (B) in paragraph (6) by striking “ one or  
24 more bona fide associations” and inserting “one

1 or more associations (as such term is defined in  
2 section 2701(d)(2)(A))”;

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

5 (4) in subsection (d)—

6 (A) in matter before paragraph (1), by  
7 striking “to a group health plan”; and

8 (B) in paragraph (2), by striking “bona  
9 fide associations” and inserting “associations  
10 (as such term is defined in section  
11 2701(d)(2)(A))”; and

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

15 **SEC. 5. PROHIBITION OF PREEXISTING CONDITION EXCLU-**  
16 **SIONS AND OTHER DISCRIMINATION BASED**  
17 **ON HEALTH STATUS.**

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

1 **“SEC. 2701. PROHIBITION OF PREEXISTING CONDITION EX-**  
2 **CLUSIONS AND OTHER DISCRIMINATION**  
3 **BASED ON HEALTH STATUS.**

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

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

9 “(1) PREEXISTING CONDITION EXCLUSION.—

10 “(A) IN GENERAL.—The term ‘preexisting  
11 condition exclusion’ means, with respect to a  
12 group health plan or health insurance coverage,  
13 a limitation or exclusion of benefits relating to  
14 a condition based on the fact that the condition  
15 was present before the date of enrollment in  
16 such plan or for such coverage, whether or not  
17 any medical advice, diagnosis, care, or treat-  
18 ment was recommended or received before such  
19 date.

20 “(B) TREATMENT OF GENETIC INFORMA-  
21 TION.—Genetic information shall not be treated  
22 as a preexisting condition in the absence of a  
23 diagnosis of the condition related to such infor-  
24 mation.

25 “(2) DATE OF ENROLLMENT.—The term ‘date  
26 of enrollment’ means, with respect to an individual

1 covered under a group health plan or health insur-  
2 ance coverage, the date of enrollment of the indi-  
3 vidual in the plan or coverage or, if earlier, the first  
4 day of the waiting period for such enrollment.

5 “(3) WAITING PERIOD.—The term ‘waiting pe-  
6 riod’ means, with respect to a group health plan and  
7 an individual who is a potential participant or bene-  
8 ficiary in the plan, the period that must pass with  
9 respect to the individual before the individual is eli-  
10 gible to be covered for benefits under the terms of  
11 the plan.

12 “(c) SPECIAL ENROLLMENT PERIODS.—

13 “(1) INDIVIDUALS LOSING OTHER COVERAGE.—  
14 A group health plan, and a health insurance issuer  
15 offering group health insurance coverage in connec-  
16 tion with a group health plan, shall permit an em-  
17 ployee who is eligible, but not enrolled, for coverage  
18 under the terms of the plan (or a dependent of such  
19 an employee if the dependent is eligible, but not en-  
20 rolled, for coverage under such terms) to enroll for  
21 coverage under the terms of the plan if each of the  
22 following conditions is met:

23 “(A) The employee or dependent was cov-  
24 ered under a group health plan or had health

1 insurance coverage at the time coverage was  
2 previously offered to the employee or dependent.

3 “(B) The employee stated in writing at  
4 such time that coverage under a group health  
5 plan or health insurance coverage was the rea-  
6 son for declining enrollment, but only if the  
7 plan sponsor or issuer (if applicable) required  
8 such a statement at such time and provided the  
9 employee with notice of such requirement (and  
10 the consequences of such requirement) at such  
11 time.

12 “(C) The employee’s or dependent’s cov-  
13 erage described in subparagraph (A)—

14 “(i) was under a COBRA continu-  
15 ation provision and the coverage under  
16 such provision was exhausted; or

17 “(ii) was not under such a provision  
18 and either the coverage was terminated as  
19 a result of loss of eligibility for the cov-  
20 erage (including as a result of legal separa-  
21 tion, divorce, death, termination of employ-  
22 ment, or reduction in the number of hours  
23 of employment) or employer contributions  
24 toward such coverage were terminated.

1           “(D) Under the terms of the plan, the em-  
2           ployee requests such enrollment not later than  
3           30 days after the date of exhaustion of coverage  
4           described in subparagraph (C)(i) or termination  
5           of coverage or employer contribution described  
6           in subparagraph (C)(ii).

7           “(2) FOR DEPENDENT BENEFICIARIES.—

8           “(A) IN GENERAL.—If—

9           “(i) a group health plan makes cov-  
10          erage available with respect to a dependent  
11          of an individual;

12          “(ii) the individual is a participant  
13          under the plan (or has met any waiting pe-  
14          riod applicable to becoming a participant  
15          under the plan and is eligible to be enrolled  
16          under the plan but for a failure to enroll  
17          during a previous enrollment period); and

18          “(iii) a person becomes such a de-  
19          pendent of the individual through mar-  
20          riage, birth, or adoption or placement for  
21          adoption,

22          the group health plan shall provide for a de-  
23          pendent special enrollment period described in  
24          subparagraph (B) during which the person (or,  
25          if not otherwise enrolled, the individual) may be

1 enrolled under the plan as a dependent of the  
2 individual, and in the case of the birth or adop-  
3 tion of a child, the spouse of the individual may  
4 be enrolled as a dependent of the individual if  
5 such spouse is otherwise eligible for coverage.

6 “(B) DEPENDENT SPECIAL ENROLLMENT  
7 PERIOD.—A dependent special enrollment pe-  
8 riod under this subparagraph shall be a period  
9 of not less than 30 days and shall begin on the  
10 later of—

11 “(i) the date dependent coverage is  
12 made available; or

13 “(ii) the date of the marriage, birth,  
14 or adoption or placement for adoption (as  
15 the case may be) described in subpara-  
16 graph (A)(iii).

17 “(C) NO WAITING PERIOD.—If an indi-  
18 vidual seeks to enroll a dependent during the  
19 first 30 days of such a dependent special enroll-  
20 ment period, the coverage of the dependent  
21 shall become effective—

22 “(i) in the case of marriage, not later  
23 than the first day of the first month begin-  
24 ning after the date the completed request  
25 for enrollment is received;



1           “(ii) in the case of a dependent’s  
2           birth, as of the date of such birth; or

3           “(iii) in the case of a dependent’s  
4           adoption or placement for adoption, the  
5           date of such adoption or placement for  
6           adoption.

7           “(3) SPECIAL RULES FOR APPLICATION IN CASE  
8           OF MEDICAID AND CHIP.—

9           “(A) IN GENERAL.—A group health plan,  
10          and a health insurance issuer offering group  
11          health insurance coverage in connection with a  
12          group health plan, shall permit an employee  
13          who is eligible, but not enrolled, for coverage  
14          under the terms of the plan (or a dependent of  
15          such an employee if the dependent is eligible,  
16          but not enrolled, for coverage under such  
17          terms) to enroll for coverage under the terms of  
18          the plan or coverage if either of the following  
19          conditions is met:

20          “(i) TERMINATION OF MEDICAID OR  
21          CHIP COVERAGE.—The employee or de-  
22          pendent is covered under a Medicaid plan  
23          under title XIX of the Social Security Act  
24          or under a State child health plan under  
25          title XXI of such Act and coverage of the

1 employee or dependent under such a plan  
2 is terminated as a result of loss of eligi-  
3 bility for such coverage and the employee  
4 requests coverage under the group health  
5 plan (or health insurance coverage) not  
6 later than 60 days after the date of termi-  
7 nation of such coverage.

8 “(ii) ELIGIBILITY FOR EMPLOYMENT  
9 ASSISTANCE UNDER MEDICAID OR CHIP.—

10 The employee or dependent becomes eligi-  
11 ble for assistance, with respect to coverage  
12 under the group health plan or health in-  
13 surance coverage, under such Medicaid  
14 plan or State child health plan (including  
15 under any waiver or demonstration project  
16 conducted under or in relation to such a  
17 plan), if the employee requests coverage  
18 under the group health plan or health in-  
19 surance coverage not later than 60 days  
20 after the date the employee or dependent is  
21 determined to be eligible for such assist-  
22 ance.

23 “(B) COORDINATION WITH MEDICAID AND  
24 CHIP.—

1           “(i) OUTREACH TO EMPLOYEES RE-  
2           GARDING AVAILABILITY OF MEDICAID AND  
3           CHIP COVERAGE.—

4                   “(I) IN GENERAL.—Each em-  
5           ployer that maintains a group health  
6           plan in a State that provides medical  
7           assistance under a State Medicaid  
8           plan under title XIX of the Social Se-  
9           curity Act, or child health assistance  
10          under a State child health plan under  
11          title XXI of such Act, in the form of  
12          premium assistance for the purchase  
13          of coverage under a group health  
14          plan, shall provide to each employee a  
15          written notice informing the employee  
16          of potential opportunities then cur-  
17          rently available in the State in which  
18          the employee resides for premium as-  
19          sistance under such plans for health  
20          coverage of the employee or the em-  
21          ployee’s dependents. For purposes of  
22          compliance with this subclause, the  
23          employer may use any State-specific  
24          model notice developed in accordance  
25          with section 701(f)(3)(B)(i)(II) of the

1 Employee Retirement Income Security  
2 Act of 1974 (29 U.S.C.  
3 1181(f)(3)(B)(i)(II)).

4 “(II) OPTION TO PROVIDE CON-  
5 CURRENT WITH PROVISION OF PLAN  
6 MATERIALS TO EMPLOYEE.—An em-  
7 ployer may provide the model notice  
8 applicable to the State in which an  
9 employee resides concurrent with the  
10 furnishing of materials notifying the  
11 employee of health plan eligibility,  
12 concurrent with materials provided to  
13 the employee in connection with an  
14 open season or election process con-  
15 ducted under the plan, or concurrent  
16 with the furnishing of the summary  
17 plan description as provided in section  
18 104(b) of the Employee Retirement  
19 Income Security Act of 1974.

20 “(ii) DISCLOSURE ABOUT GROUP  
21 HEALTH PLAN BENEFITS TO STATES FOR  
22 MEDICAID- AND CHIP-ELIGIBLE INDIVID-  
23 UALS.—In the case of an enrollee in a  
24 group health plan who is covered under a  
25 Medicaid plan of a State under title XIX

1 of the Social Security Act or under a State  
2 child health plan under title XXI of such  
3 Act, the plan administrator of the group  
4 health plan shall disclose to the State,  
5 upon request, information about the bene-  
6 fits available under the group health plan  
7 in sufficient specificity, as determined  
8 under regulations of the Secretary of  
9 Health and Human Services in consulta-  
10 tion with the Secretary that require use of  
11 the model coverage coordination disclosure  
12 form developed under section 311(b)(1)(C)  
13 of the Children’s Health Insurance Reau-  
14 thorization Act of 2009, so as to permit  
15 the State to establish (under paragraph  
16 (2)(B), (3), or (10) of section 2105(c) of  
17 the Social Security Act or otherwise) the  
18 cost effectiveness of the State providing  
19 medical or child health assistance through  
20 premium assistance for the purchase of  
21 coverage under such group health plan and  
22 in order for the State to provide supple-  
23 mental benefits required under paragraph  
24 (10)(E) of such section or other authority.

25 “(d) APPLICATION TO ASSOCIATION PLANS.—

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

7           “(2) DEFINITIONS RELATED TO ASSOCIA-  
8 TIONS.—For purposes of this subsection:

9           “(A) ASSOCIATION.—The term ‘associa-  
10 tion’ means an association that—

11                   “(i) has a constitution and bylaws;

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

16                   “(iii) has been in existence for a pe-  
17 riod of at least 5 years.

18           “(B) DEPENDENT.—The term ‘dependent’,  
19 with respect to a qualified individual, has the  
20 meaning given such term in section 2714, with  
21 respect to a policy holder.

22           “(C) QUALIFIED ACTUARY.—The term  
23 ‘qualified actuary’ means a member in good  
24 standing of the American Academy of Actu-

1 aries, or a successor organization approved by  
2 the Secretary.

3 “(D) QUALIFIED INDIVIDUALS.—The term  
4 ‘qualified individual’ means, with respect to an  
5 association, an individual who meets any of the  
6 following:

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

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

13 “(iii) An employee of the association  
14 who has been employed by the association  
15 for a period of at least 30 days.”.

16 (b) INDIVIDUAL MARKET.—Subpart 1 of part B of  
17 title XXVII of the Public Health Service Act (42 U.S.C.  
18 300gg–41 et seq.) is amended by adding at the end the  
19 following:

20 **“SEC. 2746. PROHIBITION OF PREEXISTING CONDITION EX-**  
21 **CLUSIONS OR OTHER DISCRIMINATION**  
22 **BASED ON HEALTH STATUS.**

23 “The provisions of section 2701 (other than subpara-  
24 graphs (A)(ii) and (B) of subsection (c)(3)) shall apply  
25 to health insurance coverage offered to individuals by a

1 health insurance issuer in the individual market in the  
2 same manner as it applies to health insurance coverage  
3 offered by a health insurance issuer in the group market.”.

4 **SEC. 6. NO LIFETIME OR ANNUAL LIMITS.**

5 (a) GROUP MARKET.—Subpart 2 of part A of title  
6 XXVII of the Public Health Service Act (42 U.S.C.  
7 300gg–4 et seq.) is amended by adding at the end the  
8 following:

9 **“SEC. 2708. NO LIFETIME OR ANNUAL LIMITS.**

10 “(a) IN GENERAL.—A group health plan and a health  
11 insurance issuer offering group health insurance coverage  
12 may not establish—

13 “(1) lifetime limits on the dollar value of bene-  
14 fits for any participant or beneficiary; or

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

19 “(b) PER BENEFICIARY LIMITS.—A group health  
20 plan or health insurance coverage may not place annual  
21 or lifetime per beneficiary limits on specific covered bene-  
22 fits unless such limits are otherwise permitted under Fed-  
23 eral or State law.”.

24 (b) INDIVIDUAL MARKET.—Subpart 2 of part B of  
25 title XXVII of the Public Health Service Act (42 U.S.C.



1 300gg–51 et seq.) is amended by adding at the end the  
2 following:

3 **“SEC. 2754. NO LIFETIME OR ANNUAL LIMITS.**

4 “The provisions of section 2708 shall apply to health  
5 insurance coverage offered to individuals by a health in-  
6 surance issuer in the individual market in the same man-  
7 ner as it applies to health insurance coverage offered by  
8 a health insurance issuer in the group market.”.

9 **SEC. 7. PROHIBITION ON RESCISSIONS.**

10 (a) GROUP MARKET.—Subpart 1 of part A of title  
11 XXVII of the Public Health Service Act (42 U.S.C. 300gg  
12 et seq.) is amended by adding at the end the following:

13 **“SEC. 2703. PROHIBITION ON RESCISSIONS.**

14 “A group health plan and a health insurance issuer  
15 offering group health insurance coverage shall not rescind  
16 such plan or coverage with respect to an enrollee once the  
17 enrollee is covered under such plan or coverage involved,  
18 except that this section shall not apply to a covered indi-  
19 vidual who has performed an act or practice that con-  
20 stitutes fraud or makes an intentional misrepresentation  
21 of material fact as prohibited by the terms of the plan  
22 or coverage. Such plan or coverage may not be cancelled  
23 except with prior notice to the enrollee, and only as per-  
24 mitted under section 2712(b).”.

1 (b) INDIVIDUAL MARKET.—Subpart 1 of part B of  
2 title XXVII of the Public Health Service Act (42 U.S.C.  
3 300gg–41 et seq.) is amended by adding at the end the  
4 following:

5 **“SEC. 2747. PROHIBITION ON RESCISSIONS.**

6 “The provisions of section 2703 shall apply to health  
7 insurance coverage offered to individuals by a health in-  
8 surance issuer in the individual market in the same man-  
9 ner as it applies to health insurance coverage offered by  
10 a health insurance issuer in the group market.”.

11 **SEC. 8. EXTENSION OF DEPENDENT COVERAGE.**

12 (a) GROUP MARKET.—

13 (1) IN GENERAL.—Subpart 1 of part A of title  
14 XXVII of the Public Health Service Act (42 U.S.C.  
15 300gg et seq.) is amended by adding at the end:

16 **“SEC. 2703A. EXTENSION OF DEPENDENT COVERAGE.**

17 “(a) IN GENERAL.—A group health plan and a health  
18 insurance issuer offering group health insurance coverage  
19 that provides dependent coverage of children shall con-  
20 tinue to make such coverage available for such a depend-  
21 ent after such dependent turns 18 years of age until the  
22 first of the following events occurs:

23 “(1) The dependent turns 26 years of age.

24 “(2) The dependent marries.

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

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

5                   “(B) in the case that the policy holder  
6 through which such dependent is eligible for de-  
7 pendent coverage provides such coverage subject  
8 to an order to provide child support, the de-  
9 pendent’s parent or legal guardian.

10           “(b) EXCEPTION FOR COLLEGE STUDENTS.—Para-  
11 graph (3) of subsection (a) shall not apply to a dependent  
12 for any period of time during which such dependent is en-  
13 rolled as a full-time student at a postsecondary edu-  
14 cational institution (including an institution of higher edu-  
15 cation as defined in section 102 of the Higher Education  
16 Act of 1965).

17           “(c) LIMITATION.—Nothing in this section shall re-  
18 quire a plan or an issuer described in subsection (a) to  
19 make coverage available for a child of an individual receiv-  
20 ing dependent coverage pursuant to this section.

21           “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
22 tion shall be construed to modify the definition of ‘depend-  
23 ent’ as used in the Internal Revenue Code of 1986 with  
24 respect to the tax treatment of the cost of coverage.”.

1           (2) REGULATIONS.—The Secretary shall pro-  
 2 mulgate regulations to define the dependents to  
 3 which coverage shall be made available under section  
 4 2703A of the Public Health Service Act, as added  
 5 by paragraph (1).

6           (b) INDIVIDUAL MARKET.—Subpart 1 of part B of  
 7 title XXVII of the Public Health Service Act (42 U.S.C.  
 8 300gg–41 et seq.) is amended by adding at the end the  
 9 following:

10 **“SEC. 2748. EXTENSION OF DEPENDENT COVERAGE.**

11           “The provisions of section 2703A shall apply to  
 12 health insurance coverage offered to individuals by a  
 13 health insurance issuer in the individual market in the  
 14 same manner as it applies to health insurance coverage  
 15 offered by a health insurance issuer in the group market.”.

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

19           (a) ERISA.—

20           (1) IN GENERAL.—Subpart A of title VII of the  
 21 Employee Retirement Income Security Act of 1974  
 22 (29 U.S.C. 1181 et seq.) is amended—

23           (A) by striking sections 701 and 703; and

24           (B) by inserting before section 702 the fol-  
 25 lowing:

1 **“SEC. 701. APPLICATION OF CERTAIN PHSA REQUIRE-**  
2 **MENTS.**

3 “(a) IN GENERAL.—Sections 2701, 2703, 2703A,  
4 2708, 2711, and 2712 of the Public Health Service Act  
5 shall apply to group health plans, and health insurance  
6 issuers providing health insurance coverage in connection  
7 with group health plans, as if included in this subpart.

8 “(b) CONFLICT.—To the extent that any provision of  
9 this part conflicts with a provision of any section of the  
10 Public Health Service Act listed in subsection (a) with re-  
11 spect to group health plans, or health insurance issuers  
12 providing health insurance coverage in connection with  
13 group health plans, the provisions of such sections shall  
14 apply.”.

15 (2) CONFORMING AMENDMENT.—The table of  
16 contents in section 1 of such Act (29 U.S.C. 1001  
17 note) is amended—

18 (A) by striking the item related to section  
19 701 and inserting “Sec. 701. Application of cer-  
20 tain PHSA requirements.”; and

21 (B) by striking the item related to section  
22 703.

23 (b) INTERNAL REVENUE CODE OF 1986.—Sub-  
24 chapter A of chapter 100 of the Internal Revenue Code  
25 of 1986 (relating to group health plan requirements) is  
26 amended—

1 (1) by striking sections 9801 and 9803; and

2 (2) by inserting before section 9802 the fol-  
3 lowing:

4 **“SEC. 9801. APPLICATION OF CERTAIN PHSA REQUIRE-**  
5 **MENTS.**

6 “(a) IN GENERAL.—Sections 2701, 2703, 2703A,  
7 2708, 2711, and 2712 of the Public Health Service Act  
8 shall apply to group health plans, and health insurance  
9 issuers providing health insurance coverage in connection  
10 with group health plans, as if included in this subchapter.

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

18 **SEC. 10. CATASTROPHIC PLAN.**

19 Subpart 1 of part B of title XXVII of the Public  
20 Health Service Act (42 U.S.C. 300gg–41 et seq.) is  
21 amended by adding at the end the following:

22 **“SEC. 2749. CATASTROPHIC PLAN.**

23 “(a) IN GENERAL.—Each health insurance issuer  
24 that offers health insurance coverage in the individual

1 market in a State shall offer a catastrophic plan in such  
2 State in such market.

3 “(b) COVERAGE REQUIREMENTS.—To meet the re-  
4 quirements of this section, a catastrophic plan must pro-  
5 vide for the essential health benefits, as defined by the  
6 Secretary under subsection (c).

7 “(c) ESSENTIAL HEALTH BENEFITS.—The Sec-  
8 retary shall define the essential health benefits, except  
9 that such benefits shall include—

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

12 “(2) at least the following general categories  
13 and the items and services covered within the cat-  
14 egories:

15 “(A) Ambulatory patient services.

16 “(B) Emergency services.

17 “(C) Hospitalization.

18 “(D) Maternity and newborn care.

19 “(E) Mental health and substance use dis-  
20 order services, including behavioral health treat-  
21 ment.

22 “(F) Prescription drugs.

23 “(G) Rehabilitative and habilitative serv-  
24 ices and devices.

25 “(H) Laboratory services.

1           “(I) Preventive and wellness services and  
2           chronic disease management.

3           “(J) Pediatric services, including oral and  
4           vision care.

5           “(d) RESTRICTION TO INDIVIDUAL MARKET.—If a  
6 health insurance issuer offers a health plan described in  
7 this section, the issuer may only offer the plan in the indi-  
8 vidual market.”.

9   **SEC. 11. GRANTS FOR HEALTH INSURANCE RISK ADJUST-**  
10                           **MENT MECHANISMS.**

11           (a) IN GENERAL.—The Secretary of Health and  
12 Human Services shall make grants to States for planning  
13 for the establishment and implementation of health insur-  
14 ance risk adjustment mechanisms.

15           (b) AMOUNT.—

16           (1) IN GENERAL.—The Secretary shall deter-  
17 mine the amount of a grant made to a State under  
18 this section pursuant to a formula, issued by rule  
19 not later than one year after the date of the enact-  
20 ment of the PPACA repeal legislation described in  
21 section 2(b), that takes into account the number of  
22 high-risk individuals in such State.

23           (2) LIMITATION.—The amount of a grant made  
24 to a State under this section shall not exceed  
25 \$1,000,000 for any fiscal year.



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

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

8                 (1) HIGH-RISK INDIVIDUAL.—The term “high-  
9 risk individual” means an individual who—

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

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

18                         (C) has a preexisting condition, as deter-  
19 mined in a manner consistent with guidance  
20 issued by the Secretary.

21                 (2) HEALTH INSURANCE RISK-ADJUSTMENT  
22 MECHANISMS.—

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

1           ment mechanism” shall be a mechanism that  
2           applies to—

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

6                   (ii) all covered lives for health insur-  
7                   ance coverage offered in such State that is  
8                   subject to the requirements of section 2711  
9                   or section 2741 of the Public Health Serv-  
10                  ice Act, as added by section 3 of this Act.

11                (B) FURTHER DEFINITION.—With respect  
12                to a State, any further definition of such term  
13                shall be determined by the State insurance com-  
14                missioner, acting in cooperation with health in-  
15                surance issuers who offer health insurance cov-  
16                erage in such State.

17                (3) STATE.—The term “State” means each of  
18                the 50 States and the District of Columbia.

19                (e) SUNSET DATE.—The Secretary may not make  
20                any grants under this section after the date that is 2 years  
21                after the date of the enactment of the PPACA repeal legis-  
22                lation described in section 2(b).

1 **SEC. 12. LIABILITY PROTECTIONS FOR HEALTH CARE PRO-**  
2 **VIDERS.**

3 (a) HEALTH CARE PROVIDERS PROTECTED.—The li-  
4 ability protections in subsection (c) shall apply in any civil  
5 action, including an action before any court of any State,  
6 against a health care provider, arising from health care  
7 goods or services that—

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

12 (2) were provided only because they were re-  
13 quired under section 1867 of the Social Security Act  
14 (42 U.S.C. 1395dd).

15 (b) BURDEN OF PROOF.—In any proceeding under  
16 subsection (a), the burden of proof shall be on the defend-  
17 ant to establish the elements in paragraphs (1) and (2)  
18 of subsection (a).

19 (c) LIABILITY PROTECTIONS.—

20 (1) CAP ON NONECONOMIC DAMAGES.—The  
21 amount of noneconomic damages, if available, shall  
22 not exceed \$250,000, regardless of the number of  
23 parties against whom the action is brought with re-  
24 spect to the same injury. An award for noneconomic  
25 damages in excess of \$250,000 shall be reduced ei-

1 ther before entry of the order granting judgment, or  
2 by amendment of such order.

3 (2) INSTALLMENT PAYMENTS.—If the award  
4 for damages exceeds \$50,000, the defendant may  
5 pay such damages in installments, as determined by  
6 the court.

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

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

11 (B)  $33\frac{1}{3}$  percent of the portion of the  
12 award amount that exceeds \$50,000 but does  
13 not exceed \$100,000;

14 (C) 25 percent of the portion of the award  
15 amount that exceeds \$100,000 but does not ex-  
16 ceed \$600,000; and

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

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

23 (5) PREEMPTION.—

24 (A) IN GENERAL.—The provisions of this  
25 Act preempt, subject to subparagraphs (B) and

1 (C), State law to the extent that State law pre-  
2 vents the application of any provisions of law  
3 established by or under this Act. The provisions  
4 governing an action described in subsection (a)  
5 set forth in this Act supersede chapter 171 of  
6 title 28, United States Code, to the extent that  
7 such chapter—

8 (i) provides for a greater amount of  
9 damages or contingent fees, a longer pe-  
10 riod in which a health care lawsuit may be  
11 commenced, or a reduced applicability or  
12 scope of periodic payment of future dam-  
13 ages, than provided in this Act; or

14 (ii) prohibits the introduction of evi-  
15 dence regarding collateral source benefits,  
16 or mandates or permits subrogation or a  
17 lien on collateral source benefits.

18 (B) GREATER PROTECTIONS PRE-  
19 SERVED.—This Act shall not preempt or super-  
20 sede any State or Federal law that imposes  
21 greater procedural or substantive protections  
22 for health care providers from liability, loss, or  
23 damages than those provided by this Act or cre-  
24 ate a cause of action.

1 (C) RULE OF CONSTRUCTION.—No provi-  
2 sion of this Act shall be construed to preempt—

3 (i) any State law (whether effective  
4 before, on, or after the date of the enact-  
5 ment of this Act) that specifies a par-  
6 ticular monetary amount of compensatory  
7 or punitive damages (or the total amount  
8 of damages) that may be awarded in an  
9 action described in subsection (a), regard-  
10 less of whether such monetary amount is  
11 greater or lesser than is provided for under  
12 this Act; or

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

17 (6) DEFINITIONS.—

18 (A) COLLATERAL SOURCE BENEFITS.—As  
19 used in this section, the term “collateral source  
20 benefits” means any amount paid or reasonably  
21 likely to be paid in the future to or on behalf  
22 of the claimant, or any service, product, or  
23 other benefit provided or reasonably likely to be  
24 provided in the future to or on behalf of the

1 claimant, as a result of the personal harm, pur-  
2 suant to—

3 (i) any State or Federal health, sick-  
4 ness, income-disability, accident, or work-  
5 ers' compensation law;

6 (ii) any health, sickness, income-dis-  
7 ability, or accident insurance that provides  
8 health benefits or income-disability cov-  
9 erage;

10 (iii) any contract or agreement of any  
11 group, organization, partnership, or cor-  
12 poration to provide, pay for, or reimburse  
13 the cost of medical, hospital, dental, or in-  
14 come-disability benefits; and

15 (iv) any other publicly or privately  
16 funded program.

17 (B) NONECONOMIC DAMAGES.—As used in  
18 this section, the term “noneconomic damages”  
19 means damages for physical and emotional  
20 pain, suffering, inconvenience, physical impair-  
21 ment, mental anguish, disfigurement, loss of en-  
22 joyment of life, loss of society and companion-  
23 ship, loss of consortium (other than loss of do-  
24 mestic service), hedonic damages, injury to rep-

1           utation, and all other nonpecuniary losses of  
2           any kind or nature.

3           (C) HEALTH CARE PROVIDER.—As used in  
4           this section, the term “health care provider”  
5           means any person or entity required by State or  
6           Federal laws or regulations to be licensed, reg-  
7           istered, or certified to provide health care serv-  
8           ices, and being either so licensed, registered, or  
9           certified, or exempted from such requirement by  
10          other statute.

11          (D) HEALTH CARE GOODS OR SERVICES.—  
12          As used in this section, the term “health care  
13          goods or services” means any goods or services  
14          provided by a health care organization, pro-  
15          vider, or by any individual working under the  
16          supervision of a health care provider, that re-  
17          lates to the diagnosis, prevention, or treatment  
18          of any human disease or impairment, or the as-  
19          sessment or care of the health of human beings.

○