(d) GAO report on treatment disclosures

Not later than one year after February 17, 2009, the Comptroller General of the United States shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report on the best practices related to the disclosure among health care providers of protected health information of an individual for purposes of treatment of such individual. Such report shall include an examination of the best practices implemented by States and by other entities, such as health information exchanges and regional health information organizations, an examination of the extent to which such best practices are successful with respect to the quality of the resulting health care provided to the individual and with respect to the ability of the health care provider to manage such best practices, and an examination of the use of electronic informed consent for disclosing protected health information for treatment, payment, and health care operations.

(e) Report required

Not later than 5 years after February 17, 2009, the Government Accountability Office shall submit to Congress and the Secretary of Health and Human Services a report on the impact of any of the provisions of this Act on health insurance premiums, overall health care costs, adoption of electronic health records by providers, and reduction in medical errors and other quality improvements.

(f) Study

The Secretary shall study the definition of ''psychotherapy notes'' in section 164.501 of title 45, Code of Federal Regulations, with regard to including test data that is related to direct responses, scores, items, forms, protocols, manuals, or other materials that are part of a mental health evaluation, as determined by the mental health professional providing treatment or evaluation in such definitions and may, based on such study, issue regulations to revise such definition.

(Pub. L. 111–5, div. A, title XIII, §13424, Feb. 17, 2009, 123 Stat. 276.)

REFERENCES IN TEXT

This subchapter, referred to in subsec. (a)(1), was in the original ''this subtitle'', meaning subtitle D (§13400 et seq.) of title XIII of div. A of Pub. L. 111–5, Feb. 17, 2009, 123 Stat. 258, which is classified principally to this subchapter. For complete classification of subtitle D to the Code, see Tables.

This Act, referred to in subsec. (e), means div. A of Pub. L. 111–5, Feb. 17, 2009, 123 Stat. 116, see section 4 of Pub. L. 111–5, set out as a note under section 1 of Title 1, General Provisions. For complete classification of div. A to the Code, see Tables.

CHAPTER 157—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

SUBCHAPTER I—IMMEDIATE ACTIONS TO PRESERVE AND EXPAND COVERAGE

Sec.

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PART A—INDIVIDUAL RESPONSIBILITY

SUBCHAPTER I—IMMEDIATE ACTIONS TO PRESERVE AND EXPAND COVERAGE

§ 18001. Immediate access to insurance for uninsured individuals with a preexisting condition

(a) In general

Not later than 90 days after March 23, 2010, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) Administration

(1) In general

The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) Eligible entities

To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) Maintenance of effort

To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) Qualified high risk pool

(1) In general

Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) Requirements

A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage—

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of title 26 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as provided for under section 300gg of this title (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) Eligible individual

An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 18081 of this title);

(2) has not been covered under creditable coverage (as defined in section 300gg(c)(1) of this title as in effect on March 23, 2010) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) Protection against dumping risk by insurers

(1) In general

The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) Sanctions

An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of