

110TH CONGRESS
2D SESSION

H. R. 5955

To provide for comprehensive health reform.

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 2008

Mr. WALBERG (for himself, Mr. FRANKS of Arizona, Mr. FEENEY, Mr. KLINE of Minnesota, Mr. TIAHRT, Mr. CHABOT, and Mr. BARTLETT of Maryland) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, Judiciary, and Ways and Means, 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 comprehensive health reform.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Making Health Care More Affordable Act of 2008”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH INSURANCE TAX CREDIT

- Sec. 101. Refundable credit for health insurance coverage.
- Sec. 102. Advance payment of credit for purchasers of qualified health insurance.

TITLE II—SMALL BUSINESS HEALTH PLANS

- Sec. 201. Rules governing association health plans.
- Sec. 202. Clarification of treatment of single employer arrangements.
- Sec. 203. Enforcement provisions relating to association health plans.
- Sec. 204. Cooperation between Federal and State authorities.
- Sec. 205. Effective date and transitional and other rules.

TITLE III—PURCHASE HEALTH INSURANCE ACROSS STATE LINES

- Sec. 301. Cooperative governing of individual health insurance coverage.
- Sec. 302. Severability.

TITLE IV—EXPANSION OF HEALTH SAVINGS ACCOUNTS

Subtitle A—Promoting Health for Future Generations

- Sec. 401. Short title.
- Sec. 402. Increase in HSA contribution limitation.
- Sec. 403. Medicare and VA healthcare enrollees eligible to contribute to HSA.
- Sec. 404. Expanding additional contributions limitation.
- Sec. 405. Eligibility to contribute to HSA.
- Sec. 406. Deduction of premiums for high deductible health plans.
- Sec. 407. MSA plan deductible exception for preventive care.
- Sec. 408. Permitting individual contributions to Medicare Advantage MSA.
- Sec. 409. Allowing MSA and HSA rollover to adult child of account holder.
- Sec. 410. Permitting Medicare Advantage MSA funds to be used for wellness and fitness programs.
- Sec. 411. Health reimbursement arrangements and spending arrangements in combination with health savings accounts.
- Sec. 412. Special rule for certain medical expenses incurred before establishment of account.
- Sec. 413. Allow both spouses to make catch-up contributions to the same HSA account.
- Sec. 414. FSA and HRA Termination to fund HSAs.

Subtitle B—Increased Access to Health Insurance Through HSAs

- Sec. 421. Short title.
- Sec. 422. Purchase of health insurance from health savings accounts.

TITLE V—HEALTH CARE TORT REFORM

- Sec. 501. Findings and purpose.
- Sec. 502. Encouraging speedy resolution of claims.
- Sec. 503. Compensating patient injury.
- Sec. 504. Maximizing patient recovery.
- Sec. 505. Additional health tort reform benefits.
- Sec. 506. Punitive damages.
- Sec. 507. Authorization of payment of future damages to claimants in health care lawsuits.
- Sec. 508. Definitions.
- Sec. 509. Effect on other laws.

- Sec. 510. State flexibility and protection of states' rights.
 Sec. 511. Applicability; effective date.
 Sec. 512. Sense of Congress.

TITLE VI—HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

- Sec. 601. Purpose.
 Sec. 602. Health record banking.
 Sec. 603. Application of Federal and State security and confidentiality standards.

Subtitle B—Promoting the Use of Health Information Technology to Better Coordinate Health Care

- Sec. 611. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.
 Sec. 612. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training services to health care professionals.
 Sec. 613. Rules of construction regarding use of consortia.

1 **TITLE I—HEALTH INSURANCE** 2 **TAX CREDIT**

3 **SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE** 4 **COVERAGE.**

5 (a) IN GENERAL.—Subpart C of part IV of sub-
 6 chapter A of chapter 1 of the Internal Revenue Code of
 7 1986 (relating to refundable credits) is amended by redес-
 8 ignating section 36 as section 37 and by inserting after
 9 section 35 the following new section:

10 **“SEC. 36. QUALIFIED HEALTH INSURANCE TAX CREDIT.**

11 “(a) IN GENERAL.—In the case of an individual,
 12 there shall be allowed as a credit against the tax imposed
 13 by this subtitle an amount equal to the amount paid dur-
 14 ing the taxable year for qualified health insurance for the
 15 taxpayer and the taxpayer’s spouse or dependent.

1 “(b) LIMITATIONS.—

2 “(1) IN GENERAL.—The amount allowed as a
3 credit under subsection (a) to the taxpayer for the
4 taxable year shall not exceed the sum of the monthly
5 limitations for coverage months during such taxable
6 year for the individual referred to in subsection (a)
7 for whom the taxpayer paid during the taxable year
8 any amount for coverage under qualified health in-
9 surance.

10 “(2) MONTHLY LIMITATION.—

11 “(A) IN GENERAL.—The monthly limita-
12 tion for an individual for each coverage month
13 of such individual during the taxable year is the
14 amount equal to $\frac{1}{12}$ of the qualified health in-
15 surance amount.

16 “(B) QUALIFIED HEALTH INSURANCE
17 AMOUNT.—For purposes of this paragraph, the
18 qualified health insurance amount is—

19 “(i) \$2,500 if such individual is the
20 taxpayer,

21 “(ii) \$2,500 if such individual is the
22 spouse of the taxpayer, the taxpayer and
23 such spouse are married as of the first day
24 of such month, and the taxpayer files a
25 joint return for the taxable year, or

1 “(iii) \$500 if such individual is an in-
2 dividual for whom a deduction under sec-
3 tion 151(c) is allowable to the taxpayer for
4 such taxable year.

5 “(C) LIMITATION ON DEPENDENTS.—Not
6 more than 2 individuals may be taken into ac-
7 count by the taxpayer under subparagraph
8 (B)(iii).

9 “(3) COVERAGE MONTH.—For purposes of this
10 subsection—

11 “(A) IN GENERAL.—The term ‘coverage
12 month’ means, with respect to an individual,
13 any month if—

14 “(i) as of the first day of such month
15 such individual is covered by qualified
16 health insurance, and

17 “(ii) the premium for coverage under
18 such insurance for such month is paid by
19 the taxpayer.

20 “(B) MEDICARE.—Such term shall not in-
21 clude any month with respect to an individual
22 if, as of the first day of such month, such indi-
23 vidual has not made an election to establish and
24 maintain a Medical Retirement Account under
25 section 252(a)(2) of the Social Security Act and

1 is entitled to benefits under title XVIII of the
2 Social Security Act.

3 “(C) CERTAIN OTHER COVERAGE.—Such
4 term shall not include any month during a tax-
5 able year with respect to an individual if, at any
6 time during such year, any benefit is provided
7 to such individual under—

8 “(i) chapter 55 of title 10, United
9 States Code,

10 “(ii) chapter 17 of title 38, United
11 States Code, or

12 “(iii) any medical care program under
13 the Indian Health Care Improvement Act.

14 “(D) PRISONERS.—Such term shall not in-
15 clude any month with respect to an individual
16 if, as of the first day of such month, such indi-
17 vidual is imprisoned under Federal, State, or
18 local authority.

19 “(E) INSUFFICIENT PRESENCE IN UNITED
20 STATES.—Such term shall not include any
21 month during a taxable year with respect to an
22 individual if such individual is present in the
23 United States on fewer than 183 days during
24 such year (determined in accordance with sec-
25 tion 7701(b)(7)).

1 “(c) QUALIFIED HEALTH INSURANCE.—For pur-
2 poses of this section—

3 “(1) IN GENERAL.—The term ‘qualified health
4 insurance’ means any health plan (within the mean-
5 ing of section 223(c)(2)) determined without regard
6 to any annual deductible requirement.

7 “(2) ANNUAL WELLNESS EXAM.—Such term
8 shall include an annual wellness exam fee not to ex-
9 ceed \$150 (\$100 in the case of an annual child
10 wellness exam) if such exam is not covered by the
11 insurance.

12 “(d) ARCHER MSA AND HEALTH SAVINGS ACCOUNT
13 CONTRIBUTIONS.—

14 “(1) IN GENERAL.—If a deduction would (but
15 for paragraph (2)) be allowed under section 220 or
16 223 to the taxpayer for a payment for the taxable
17 year to the Archer MSA or health savings account
18 of an individual, subsection (a) shall be applied by
19 treating such payment as a payment for qualified
20 health insurance for such individual.

21 “(2) DENIAL OF DOUBLE BENEFIT.—No deduc-
22 tion shall be allowed under section 220 or 223 for
23 that portion of the payments otherwise allowable as
24 a deduction under section 220 or 223 for the taxable

1 year which is equal to the amount of credit allowed
2 for such taxable year by reason of this subsection.

3 “(e) SPECIAL RULES.—For purposes of this sec-
4 tion—

5 “(1) MARRIED COUPLES MUST FILE JOINT RE-
6 TURN.—If the taxpayer is married at the close of
7 the taxable year, the credit shall be allowed under
8 subsection (a) only if the taxpayer and the tax-
9 payer’s spouse file a joint return for the taxable
10 year.

11 “(2) DENIAL OF CREDIT TO DEPENDENTS.—No
12 credit shall be allowed under this section to any indi-
13 vidual with respect to whom a deduction under sec-
14 tion 151 is allowable to another taxpayer for a tax-
15 able year beginning in the calendar year in which
16 such individual’s taxable year begins.

17 “(3) DENIAL OF DOUBLE BENEFIT.—No credit
18 shall be allowed under subsection (a) if the credit
19 under section 35 is allowed and no credit shall be al-
20 lowed under 35 if a credit is allowed under this sec-
21 tion.

22 “(4) COORDINATION WITH DEDUCTION FOR
23 HEALTH INSURANCE COSTS.—In the case of a tax-
24 payer who is eligible to deduct any amount under
25 section 162(l) or 213 for the taxable year, this sec-

1 tion shall apply only if the taxpayer elects not to
2 claim any amount as a deduction under such section
3 for such year.

4 “(5) ELECTION NOT TO CLAIM CREDIT.—This
5 section shall not apply to a taxpayer for any taxable
6 year if such taxpayer elects to have this section not
7 apply for such taxable year.

8 “(6) INFLATION ADJUSTMENT.—

9 “(A) IN GENERAL.—In the case of any
10 taxable year beginning in a calendar year after
11 2008, each dollar amount contained in sub-
12 section (b)(2)(B) shall be increased by an
13 amount equal to—

14 “(i) such dollar amount, multiplied by

15 “(ii) the cost-of-living adjustment de-
16 termined under subparagraph (B) for the
17 calendar year in which such taxable year
18 begins.

19 “(B) COST-OF-LIVING ADJUSTMENT.—For
20 purposes of subparagraph (A), the cost-of-living
21 adjustment for any calendar year is the per-
22 centage (if any) by which—

23 “(i) the GDP for the preceding cal-
24 endar year, exceeds

25 “(ii) the GDP for calendar year 2007.

1 “(C) GDP FOR ANY CALENDAR YEAR.—
2 For purposes of subparagraph (B), the GDP
3 for any calendar year is the average of the
4 chain-weighted price index for the gross domes-
5 tic product as of the close of the 12-month pe-
6 riod ending on March 31 of such calendar year.

7 “(D) CHAIN-WEIGHTED PRICE INDEX FOR
8 THE GROSS DOMESTIC PRODUCT.—For pur-
9 poses of subparagraph (C), the term ‘chain-
10 weighted price index for the gross domestic
11 product’ means the last chain-weighted price
12 index for the gross domestic product published
13 by the Department of Commerce.

14 “(E) ROUNDING.—Any increase deter-
15 mined under subparagraph (A) shall be rounded
16 to the nearest multiple of \$50.”.

17 (b) INFORMATION REPORTING.—

18 (1) IN GENERAL.—Subpart B of part III of
19 subchapter A of chapter 61 of the Internal Revenue
20 Code of 1986 (relating to information concerning
21 transactions with other persons) is amended by in-
22 serting after section 6050V the following new sec-
23 tion:

1 **“SEC. 6050W. RETURNS RELATING TO PAYMENTS FOR**
2 **QUALIFIED HEALTH INSURANCE.**

3 “(a) IN GENERAL.—Any person who, in connection
4 with a trade or business conducted by such person, re-
5 ceives payments during any calendar year from any indi-
6 vidual for coverage of such individual or any other indi-
7 vidual under creditable health insurance, shall make the
8 return described in subsection (b) (at such time as the
9 Secretary may by regulations prescribe) with respect to
10 each individual from whom such payments were received.

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

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

15 “(2) contains—

16 “(A) the name, address, and TIN of the
17 individual from whom payments described in
18 subsection (a) were received,

19 “(B) the name, address, and TIN of each
20 individual who was provided by such person
21 with coverage under creditable health insurance
22 by reason of such payments and the period of
23 such coverage, and

24 “(C) such other information as the Sec-
25 retary may reasonably prescribe.

1 “(c) CREDITABLE HEALTH INSURANCE.—For pur-
2 poses of this section, the term ‘creditable health insurance’
3 means qualified health insurance (as defined in section
4 36(c)) other than, to the extent provided in regulations
5 prescribed by the Secretary, any insurance covering an in-
6 dividual if no credit is allowable under section 36 with re-
7 spect to such coverage.

8 “(d) STATEMENTS TO BE FURNISHED TO INDIVID-
9 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
10 QUIRED.—Every person required to make a return under
11 subsection (a) shall furnish to each individual whose name
12 is required under subsection (b)(2)(A) to be set forth in
13 such return a written statement showing—

14 “(1) the name and address of the person re-
15 quired to make such return and the phone number
16 of the information contact for such person,

17 “(2) the aggregate amount of payments de-
18 scribed in subsection (a) received by the person re-
19 quired to make such return from the individual to
20 whom the statement is required to be furnished, and

21 “(3) the information required under subsection
22 (b)(2)(B) with respect to such payments.

23 The written statement required under the preceding sen-
24 tence shall be furnished on or before January 31 of the

1 year following the calendar year for which the return
2 under subsection (a) is required to be made.

3 “(e) RETURNS WHICH WOULD BE REQUIRED TO BE
4 MADE BY 2 OR MORE PERSONS.—Except to the extent
5 provided in regulations prescribed by the Secretary, in the
6 case of any amount received by any person on behalf of
7 another person, only the person first receiving such
8 amount shall be required to make the return under sub-
9 section (a).”.

10 (2) ASSESSABLE PENALTIES.—

11 (A) Subparagraph (B) of section
12 6724(d)(1) of such Code (relating to defini-
13 tions) is amended by redesignating clauses (xv)
14 through (xx) as clauses (xvi) through (xxi), re-
15 spectively, and by inserting after clause (xi) the
16 following new clause:

17 “(xv) section 6050W (relating to re-
18 turns relating to payments for qualified
19 health insurance),”.

20 (B) Paragraph (2) of section 6724(d) of
21 such Code is amended by striking the period at
22 the end of subparagraph (CC) and inserting “,
23 or” and by adding at the end the following new
24 subparagraph:

1 “(DD) section 6050W(d) (relating to re-
2 turns relating to payments for qualified health
3 insurance).”.

4 (3) CLERICAL AMENDMENT.—The table of sec-
5 tions for subpart B of part III of subchapter A of
6 chapter 61 of such Code is amended by inserting
7 after the item relating to section 6050V the fol-
8 lowing new item:

 “Sec. 6050W. Returns relating to payments for qualified health insurance.”.

9 (c) CONFORMING AMENDMENTS.—

10 (1) Paragraph (2) of section 1324(b) of title
11 31, United States Code, is amended by inserting be-
12 fore the period “, or from section 36 of such Code”.

13 (2) The table of sections for subpart C of part
14 IV of subchapter A of chapter 1 of the Internal Rev-
15 enue Code of 1986 is amended by striking the last
16 item and inserting the following new items:

 “Sec. 36. Qualified health insurance tax credit.

 “Sec. 37. Overpayments of tax.”.

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

1 **SEC. 102. ADVANCE PAYMENT OF CREDIT FOR PUR-**
2 **CHASERS OF QUALIFIED HEALTH INSUR-**
3 **ANCE.**

4 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
5 enue Code of 1986 (relating to miscellaneous provisions)
6 is amended by adding at the end the following new section:

7 **“SEC. 7529. ADVANCE PAYMENT OF QUALIFIED HEALTH IN-**
8 **SURANCE TAX CREDIT.**

9 “(a) GENERAL RULE.—In the case of an eligible indi-
10 vidual, the Secretary shall make payments to the provider
11 of such individual’s qualified health insurance equal to
12 such individual’s qualified health insurance credit advance
13 amount with respect to such provider.

14 “(b) ELIGIBLE INDIVIDUAL.—For purposes of this
15 section, the term ‘eligible individual’ means any indi-
16 vidual—

17 “(1) who purchases qualified health insurance
18 (as defined in section 36(c)), and

19 “(2) for whom a qualified health insurance
20 credit eligibility certificate is in effect.

21 “(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGI-
22 BILITY CERTIFICATE.—For purposes of this section, a
23 qualified health insurance credit eligibility certificate is a
24 statement furnished by an individual to the Secretary
25 which—

1 “(1) certifies that the individual will be eligible
2 to receive the credit provided by section 36 for the
3 taxable year,

4 “(2) estimates the amount of such credit for
5 such taxable year, and

6 “(3) provides such other information as the
7 Secretary may require for purposes of this section.

8 “(d) QUALIFIED HEALTH INSURANCE CREDIT AD-
9 VANCE AMOUNT.—For purposes of this section, the term
10 ‘qualified health insurance credit advance amount’ means,
11 with respect to any provider of qualified health insurance,
12 the Secretary’s estimate of the amount of credit allowable
13 under section 36 to the individual for the taxable year
14 which is attributable to the insurance provided to the indi-
15 vidual by such provider.

16 “(e) REGULATIONS.—The Secretary shall prescribe
17 such regulations as may be necessary to carry out the pur-
18 poses of this section.”.

19 (b) CLERICAL AMENDMENT.—The table of sections
20 for chapter 77 of the Internal Revenue Code of 1986 is
21 amended by adding at the end the following new item:

 “Sec. 7529. Advance payment of qualified health insurance tax credit.”.

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

1 **TITLE II—SMALL BUSINESS**
2 **HEALTH PLANS**

3 **SEC. 201. RULES GOVERNING ASSOCIATION HEALTH**
4 **PLANS.**

5 (a) IN GENERAL.—Subtitle B of title I of the Em-
6 ployee Retirement Income Security Act of 1974 is amend-
7 ed by adding after part 7 the following new part:

8 **“PART 8—RULES GOVERNING ASSOCIATION**
9 **HEALTH PLANS**

10 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

11 “(a) IN GENERAL.—For purposes of this part, the
12 term ‘association health plan’ means a group health plan
13 whose sponsor is (or is deemed under this part to be) de-
14 scribed in subsection (b).

15 “(b) SPONSORSHIP.—The sponsor of a group health
16 plan is described in this subsection if such sponsor—

17 “(1) is organized and maintained in good faith,
18 with a constitution and bylaws specifically stating its
19 purpose and providing for periodic meetings on at
20 least an annual basis, as a bona fide trade associa-
21 tion, a bona fide industry association (including a
22 rural electric cooperative association or a rural tele-
23 phone cooperative association), a bona fide profes-
24 sional association, or a bona fide chamber of com-
25 merce (or similar bona fide business association, in-

1 including a corporation or similar organization that
2 operates on a cooperative basis (within the meaning
3 of section 1381 of the Internal Revenue Code of
4 1986)), for substantial purposes other than that of
5 obtaining or providing medical care;

6 “(2) is established as a permanent entity which
7 receives the active support of its members and re-
8 quires for membership payment on a periodic basis
9 of dues or payments necessary to maintain eligibility
10 for membership in the sponsor; and

11 “(3) does not condition membership, such dues
12 or payments, or coverage under the plan on the
13 basis of health status-related factors with respect to
14 the employees of its members (or affiliated mem-
15 bers), or the dependents of such employees, and does
16 not condition such dues or payments on the basis of
17 group health plan participation.

18 Any sponsor consisting of an association of entities which
19 meet the requirements of paragraphs (1), (2), and (3)
20 shall be deemed to be a sponsor described in this sub-
21 section.

22 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
23 **PLANS.**

24 “(a) IN GENERAL.—The applicable authority shall
25 prescribe by regulation a procedure under which, subject

1 to subsection (b), the applicable authority shall certify as-
2 sociation health plans which apply for certification as
3 meeting the requirements of this part.

4 “(b) STANDARDS.—Under the procedure prescribed
5 pursuant to subsection (a), in the case of an association
6 health plan that provides at least one benefit option which
7 does not consist of health insurance coverage, the applica-
8 ble authority shall certify such plan as meeting the re-
9 quirements of this part only if the applicable authority is
10 satisfied that the applicable requirements of this part are
11 met (or, upon the date on which the plan is to commence
12 operations, will be met) with respect to the plan.

13 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
14 PLANS.—An association health plan with respect to which
15 certification under this part is in effect shall meet the ap-
16 plicable requirements of this part, effective on the date
17 of certification (or, if later, on the date on which the plan
18 is to commence operations).

19 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
20 CATION.—The applicable authority may provide by regula-
21 tion for continued certification of association health plans
22 under this part.

23 “(e) CLASS CERTIFICATION FOR FULLY INSURED
24 PLANS.—The applicable authority shall establish a class
25 certification procedure for association health plans under

1 which all benefits consist of health insurance coverage.
2 Under such procedure, the applicable authority shall pro-
3 vide for the granting of certification under this part to
4 the plans in each class of such association health plans
5 upon appropriate filing under such procedure in connec-
6 tion with plans in such class and payment of the pre-
7 scribed fee under section 807(a).

8 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
9 HEALTH PLANS.—An association health plan which offers
10 one or more benefit options which do not consist of health
11 insurance coverage may be certified under this part only
12 if such plan consists of any of the following:

13 “(1) a plan which offered such coverage on the
14 date of the enactment of the Making Health Care
15 More Affordable Act of 2008,

16 “(2) a plan under which the sponsor does not
17 restrict membership to one or more trades and busi-
18 nesses or industries and whose eligible participating
19 employers represent a broad cross-section of trades
20 and businesses or industries, or

21 “(3) a plan whose eligible participating employ-
22 ers represent one or more trades or businesses, or
23 one or more industries, consisting of any of the fol-
24 lowing: agriculture; equipment and automobile deal-
25 erships; barbering and cosmetology; certified public

1 accounting practices; child care; construction; dance,
2 theatrical and orchestra productions; disinfecting
3 and pest control; financial services; fishing; food
4 service establishments; hospitals; labor organiza-
5 tions; logging; manufacturing (metals); mining; med-
6 ical and dental practices; medical laboratories; pro-
7 fessional consulting services; sanitary services; trans-
8 portation (local and freight); warehousing; whole-
9 salings/distributing; or any other trade or business or
10 industry which has been indicated as having average
11 or above-average risk or health claims experience by
12 reason of State rate filings, denials of coverage, pro-
13 posed premium rate levels, or other means dem-
14 onstrated by such plan in accordance with regula-
15 tions.

16 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
17 **BOARDS OF TRUSTEES.**

18 “(a) SPONSOR.—The requirements of this subsection
19 are met with respect to an association health plan if the
20 sponsor has met (or is deemed under this part to have
21 met) the requirements of section 801(b) for a continuous
22 period of not less than 3 years ending with the date of
23 the application for certification under this part.

1 “(b) BOARD OF TRUSTEES.—The requirements of
2 this subsection are met with respect to an association
3 health plan if the following requirements are met:

4 “(1) FISCAL CONTROL.—The plan is operated,
5 pursuant to a trust agreement, by a board of trust-
6 ees which has complete fiscal control over the plan
7 and which is responsible for all operations of the
8 plan.

9 “(2) RULES OF OPERATION AND FINANCIAL
10 CONTROLS.—The board of trustees has in effect
11 rules of operation and financial controls, based on a
12 3-year plan of operation, adequate to carry out the
13 terms of the plan and to meet all requirements of
14 this title applicable to the plan.

15 “(3) RULES GOVERNING RELATIONSHIP TO
16 PARTICIPATING EMPLOYERS AND TO CONTRAC-
17 TORS.—

18 “(A) BOARD MEMBERSHIP.—

19 “(i) IN GENERAL.—Except as pro-
20 vided in clauses (ii) and (iii), the members
21 of the board of trustees are individuals se-
22 lected from individuals who are the owners,
23 officers, directors, or employees of the par-
24 ticipating employers or who are partners in

1 the participating employers and actively
2 participate in the business.

3 “(ii) LIMITATION.—

4 “(I) GENERAL RULE.—Except as
5 provided in subclauses (II) and (III),
6 no such member is an owner, officer,
7 director, or employee of, or partner in,
8 a contract administrator or other
9 service provider to the plan.

10 “(II) LIMITED EXCEPTION FOR
11 PROVIDERS OF SERVICES SOLELY ON
12 BEHALF OF THE SPONSOR.—Officers
13 or employees of a sponsor which is a
14 service provider (other than a contract
15 administrator) to the plan may be
16 members of the board if they con-
17 stitute not more than 25 percent of
18 the membership of the board and they
19 do not provide services to the plan
20 other than on behalf of the sponsor.

21 “(III) TREATMENT OF PRO-
22 VIDERS OF MEDICAL CARE.—In the
23 case of a sponsor which is an associa-
24 tion whose membership consists pri-
25 marily of providers of medical care,

1 subclause (I) shall not apply in the
2 case of any service provider described
3 in subclause (I) who is a provider of
4 medical care under the plan.

5 “(iii) CERTAIN PLANS EXCLUDED.—
6 Clause (I) shall not apply to an association
7 health plan which is in existence on the
8 date of the enactment of the Making
9 Health Care More Affordable Act of 2008.

10 “(B) SOLE AUTHORITY.—The board has
11 sole authority under the plan to approve appli-
12 cations for participation in the plan and to con-
13 tract with a service provider to administer the
14 day-to-day affairs of the plan.

15 “(c) TREATMENT OF FRANCHISE NETWORKS.—In
16 the case of a group health plan which is established and
17 maintained by a franchiser for a franchise network con-
18 sisting of its franchisees—

19 “(1) the requirements of subsection (a) and sec-
20 tion 801(a) shall be deemed met if such require-
21 ments would otherwise be met if the franchiser were
22 deemed to be the sponsor referred to in section
23 801(b), such network were deemed to be an associa-
24 tion described in section 801(b), and each franchisee

1 were deemed to be a member (of the association and
2 the sponsor) referred to in section 801(b); and

3 “(2) the requirements of section 804(a)(1) shall
4 be deemed met.

5 The Secretary may by regulation define for purposes of
6 this subsection the terms ‘franchiser’, ‘franchise network’,
7 and ‘franchisee’.

8 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
9 **MENTS.**

10 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
11 requirements of this subsection are met with respect to
12 an association health plan if, under the terms of the
13 plan—

14 “(1) each participating employer must be—

15 “(A) a member of the sponsor,

16 “(B) the sponsor, or

17 “(C) an affiliated member of the sponsor

18 with respect to which the requirements of sub-

19 section (b) are met,

20 except that, in the case of a sponsor which is a pro-

21 fessional association or other individual-based asso-

22 ciation, if at least one of the officers, directors, or

23 employees of an employer, or at least one of the in-

24 dividuals who are partners in an employer and who

25 actively participates in the business, is a member or

1 such an affiliated member of the sponsor, partici-
2 pating employers may also include such employer;
3 and

4 “(2) all individuals commencing coverage under
5 the plan after certification under this part must
6 be—

7 “(A) active or retired owners (including
8 self-employed individuals), officers, directors, or
9 employees of, or partners in, participating em-
10 ployers; or

11 “(B) the beneficiaries of individuals de-
12 scribed in subparagraph (A).

13 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
14 PLOYEES.—In the case of an association health plan in
15 existence on the date of the enactment of the Making
16 Health Care More Affordable Act of 2008, an affiliated
17 member of the sponsor of the plan may be offered coverage
18 under the plan as a participating employer only if—

19 “(1) the affiliated member was an affiliated
20 member on the date of certification under this part;
21 or

22 “(2) during the 12-month period preceding the
23 date of the offering of such coverage, the affiliated
24 member has not maintained or contributed to a
25 group health plan with respect to any of its employ-

1 ees who would otherwise be eligible to participate in
2 such association health plan.

3 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
4 quirements of this subsection are met with respect to an
5 association health plan if, under the terms of the plan,
6 no participating employer may provide health insurance
7 coverage in the individual market for any employee not
8 covered under the plan which is similar to the coverage
9 contemporaneously provided to employees of the employer
10 under the plan, if such exclusion of the employee from cov-
11 erage under the plan is based on a health status-related
12 factor with respect to the employee and such employee
13 would, but for such exclusion on such basis, be eligible
14 for coverage under the plan.

15 “(d) PROHIBITION OF DISCRIMINATION AGAINST
16 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-
17 PATE.—The requirements of this subsection are met with
18 respect to an association health plan if—

19 “(1) under the terms of the plan, all employers
20 meeting the preceding requirements of this section
21 are eligible to qualify as participating employers for
22 all geographically available coverage options, unless,
23 in the case of any such employer, participation or
24 contribution requirements of the type referred to in

1 section 2711 of the Public Health Service Act are
2 not met;

3 “(2) upon request, any employer eligible to par-
4 ticipate is furnished information regarding all cov-
5 erage options available under the plan; and

6 “(3) the applicable requirements of sections
7 701, 702, and 703 are met with respect to the plan.

8 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
9 **DOCUMENTS, CONTRIBUTION RATES, AND**
10 **BENEFIT OPTIONS.**

11 “(a) IN GENERAL.—The requirements of this section
12 are met with respect to an association health plan if the
13 following requirements are met:

14 “(1) CONTENTS OF GOVERNING INSTRU-
15 MENTS.—The instruments governing the plan in-
16 clude a written instrument, meeting the require-
17 ments of an instrument required under section
18 402(a)(1), which—

19 “(A) provides that the board of trustees
20 serves as the named fiduciary required for plans
21 under section 402(a)(1) and serves in the ca-
22 pacity of a plan administrator (referred to in
23 section 3(16)(A));

1 “(B) provides that the sponsor of the plan
2 is to serve as plan sponsor (referred to in sec-
3 tion 3(16)(B)); and

4 “(C) incorporates the requirements of sec-
5 tion 806.

6 “(2) CONTRIBUTION RATES MUST BE NON-
7 DISCRIMINATORY.—

8 “(A) The contribution rates for any par-
9 ticipating small employer do not vary on the
10 basis of any health status-related factor in rela-
11 tion to employees of such employer or their
12 beneficiaries and do not vary on the basis of the
13 type of business or industry in which such em-
14 ployer is engaged.

15 “(B) Nothing in this title or any other pro-
16 vision of law shall be construed to preclude an
17 association health plan, or a health insurance
18 issuer offering health insurance coverage in
19 connection with an association health plan,
20 from—

21 “(i) setting contribution rates based
22 on the claims experience of the plan; or

23 “(ii) varying contribution rates for
24 small employers in a State to the extent
25 that such rates could vary using the same

1 methodology employed in such State for
2 regulating premium rates in the small
3 group market with respect to health insur-
4 ance coverage offered in connection with
5 bona fide associations (within the meaning
6 of section 2791(d)(3) of the Public Health
7 Service Act),

8 subject to the requirements of section 702(b)
9 relating to contribution rates.

10 “(3) FLOOR FOR NUMBER OF COVERED INDI-
11 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If
12 any benefit option under the plan does not consist
13 of health insurance coverage, the plan has as of the
14 beginning of the plan year not fewer than 1,000 par-
15 ticipants and beneficiaries.

16 “(4) MARKETING REQUIREMENTS.—

17 “(A) IN GENERAL.—If a benefit option
18 which consists of health insurance coverage is
19 offered under the plan, State-licensed insurance
20 agents shall be used to distribute to small em-
21 ployers coverage which does not consist of
22 health insurance coverage in a manner com-
23 parable to the manner in which such agents are
24 used to distribute health insurance coverage.

1 “(B) STATE-LICENSED INSURANCE
2 AGENTS.—For purposes of subparagraph (A),
3 the term ‘State-licensed insurance agents’
4 means one or more agents who are licensed in
5 a State and are subject to the laws of such
6 State relating to licensure, qualification, test-
7 ing, examination, and continuing education of
8 persons authorized to offer, sell, or solicit
9 health insurance coverage in such State.

10 “(5) REGULATORY REQUIREMENTS.—Such
11 other requirements as the applicable authority deter-
12 mines are necessary to carry out the purposes of this
13 part, which shall be prescribed by the applicable au-
14 thority by regulation.

15 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
16 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
17 nothing in this part or any provision of State law (as de-
18 fined in section 514(c)(1)) shall be construed to preclude
19 an association health plan, or a health insurance issuer
20 offering health insurance coverage in connection with an
21 association health plan, from exercising its sole discretion
22 in selecting the specific items and services consisting of
23 medical care to be included as benefits under such plan
24 or coverage, except (subject to section 514) in the case
25 of (1) any law to the extent that it is not preempted under

1 section 731(a)(1) with respect to matters governed by sec-
 2 tion 711, 712, or 713, or (2) any law of the State with
 3 which filing and approval of a policy type offered by the
 4 plan was initially obtained to the extent that such law pro-
 5 hibits an exclusion of a specific disease from such cov-
 6 erage.

7 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
 8 **FOR SOLVENCY FOR PLANS PROVIDING**
 9 **HEALTH BENEFITS IN ADDITION TO HEALTH**
 10 **INSURANCE COVERAGE.**

11 “(a) IN GENERAL.—The requirements of this section
 12 are met with respect to an association health plan if—

13 “(1) the benefits under the plan consist solely
 14 of health insurance coverage; or

15 “(2) if the plan provides any additional benefit
 16 options which do not consist of health insurance cov-
 17 erage, the plan—

18 “(A) establishes and maintains reserves
 19 with respect to such additional benefit options,
 20 in amounts recommended by the qualified actu-
 21 ary, consisting of—

22 “(i) a reserve sufficient for unearned
 23 contributions;

24 “(ii) a reserve sufficient for benefit li-
 25 abilities which have been incurred, which

1 have not been satisfied, and for which risk
2 of loss has not yet been transferred, and
3 for expected administrative costs with re-
4 spect to such benefit liabilities;

5 “(iii) a reserve sufficient for any other
6 obligations of the plan; and

7 “(iv) a reserve sufficient for a margin
8 of error and other fluctuations, taking into
9 account the specific circumstances of the
10 plan; and

11 “(B) establishes and maintains aggregate
12 and specific excess/stop loss insurance and sol-
13 vency indemnification, with respect to such ad-
14 ditional benefit options for which risk of loss
15 has not yet been transferred, as follows:

16 “(i) The plan shall secure aggregate
17 excess/stop loss insurance for the plan with
18 an attachment point which is not greater
19 than 125 percent of expected gross annual
20 claims. The applicable authority may by
21 regulation provide for upward adjustments
22 in the amount of such percentage in speci-
23 fied circumstances in which the plan spe-
24 cifically provides for and maintains re-

1 serves in excess of the amounts required
2 under subparagraph (A).

3 “(ii) The plan shall secure specific ex-
4 cess/stop loss insurance for the plan with
5 an attachment point which is at least equal
6 to an amount recommended by the plan’s
7 qualified actuary. The applicable authority
8 may by regulation provide for adjustments
9 in the amount of such insurance in speci-
10 fied circumstances in which the plan spe-
11 cifically provides for and maintains re-
12 serves in excess of the amounts required
13 under subparagraph (A).

14 “(iii) The plan shall secure indem-
15 nification insurance for any claims which
16 the plan is unable to satisfy by reason of
17 a plan termination.

18 Any person issuing to a plan insurance described in clause
19 (I), (ii), or (iii) of subparagraph (B) shall notify the Sec-
20 retary of any failure of premium payment meriting can-
21 cellation of the policy prior to undertaking such a cancella-
22 tion. Any regulations prescribed by the applicable author-
23 ity pursuant to clause (I) or (ii) of subparagraph (B) may
24 allow for such adjustments in the required levels of excess/
25 stop loss insurance as the qualified actuary may rec-

1 commend, taking into account the specific circumstances
2 of the plan.

3 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
4 RESERVES.—In the case of any association health plan de-
5 scribed in subsection (a)(2), the requirements of this sub-
6 section are met if the plan establishes and maintains sur-
7 plus in an amount at least equal to—

8 “(1) \$500,000, or

9 “(2) such greater amount (but not greater than
10 \$2,000,000) as may be set forth in regulations pre-
11 scribed by the applicable authority, considering the
12 level of aggregate and specific excess/stop loss insur-
13 ance provided with respect to such plan and other
14 factors related to solvency risk, such as the plan’s
15 projected levels of participation or claims, the nature
16 of the plan’s liabilities, and the types of assets avail-
17 able to assure that such liabilities are met.

18 “(c) ADDITIONAL REQUIREMENTS.—In the case of
19 any association health plan described in subsection (a)(2),
20 the applicable authority may provide such additional re-
21 quirements relating to reserves, excess/stop loss insurance,
22 and indemnification insurance as the applicable authority
23 considers appropriate. Such requirements may be provided
24 by regulation with respect to any such plan or any class
25 of such plans.

1 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
2 ANCE.—The applicable authority may provide for adjust-
3 ments to the levels of reserves otherwise required under
4 subsections (a) and (b) with respect to any plan or class
5 of plans to take into account excess/stop loss insurance
6 provided with respect to such plan or plans.

7 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The
8 applicable authority may permit an association health plan
9 described in subsection (a)(2) to substitute, for all or part
10 of the requirements of this section (except subsection
11 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
12 rangement, or other financial arrangement as the applica-
13 ble authority determines to be adequate to enable the plan
14 to fully meet all its financial obligations on a timely basis
15 and is otherwise no less protective of the interests of par-
16 ticipants and beneficiaries than the requirements for
17 which it is substituted. The applicable authority may take
18 into account, for purposes of this subsection, evidence pro-
19 vided by the plan or sponsor which demonstrates an as-
20 sumption of liability with respect to the plan. Such evi-
21 dence may be in the form of a contract of indemnification,
22 lien, bonding, insurance, letter of credit, recourse under
23 applicable terms of the plan in the form of assessments
24 of participating employers, security, or other financial ar-
25 rangement.

1 “(f) MEASURES TO ENSURE CONTINUED PAYMENT
2 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

3 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
4 CIATION HEALTH PLAN FUND.—

5 “(A) IN GENERAL.—In the case of an as-
6 sociation health plan described in subsection
7 (a)(2), the requirements of this subsection are
8 met if the plan makes payments into the Asso-
9 ciation Health Plan Fund under this subpara-
10 graph when they are due. Such payments shall
11 consist of annual payments in the amount of
12 \$5,000, and, in addition to such annual pay-
13 ments, such supplemental payments as the Sec-
14 retary may determine to be necessary under
15 paragraph (2). Payments under this paragraph
16 are payable to the Fund at the time determined
17 by the Secretary. Initial payments are due in
18 advance of certification under this part. Pay-
19 ments shall continue to accrue until a plan’s as-
20 sets are distributed pursuant to a termination
21 procedure.

22 “(B) PENALTIES FOR FAILURE TO MAKE
23 PAYMENTS.—If any payment is not made by a
24 plan when it is due, a late payment charge of
25 not more than 100 percent of the payment

1 which was not timely paid shall be payable by
2 the plan to the Fund.

3 “(C) CONTINUED DUTY OF THE SEC-
4 RETARY.—The Secretary shall not cease to
5 carry out the provisions of paragraph (2) on ac-
6 count of the failure of a plan to pay any pay-
7 ment when due.

8 “(2) PAYMENTS BY SECRETARY TO CONTINUE
9 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
10 DEMNFICATION INSURANCE COVERAGE FOR CER-
11 TAIN PLANS.—In any case in which the applicable
12 authority determines that there is, or that there is
13 reason to believe that there will be: (A) a failure to
14 take necessary corrective actions under section
15 809(a) with respect to an association health plan de-
16 scribed in subsection (a)(2); or (B) a termination of
17 such a plan under section 809(b) or 810(b)(8) (and,
18 if the applicable authority is not the Secretary, cer-
19 tifies such determination to the Secretary), the Sec-
20 retary shall determine the amounts necessary to
21 make payments to an insurer (designated by the
22 Secretary) to maintain in force excess/stop loss in-
23 surance coverage or indemnification insurance cov-
24 erage for such plan, if the Secretary determines that
25 there is a reasonable expectation that, without such

1 payments, claims would not be satisfied by reason of
2 termination of such coverage. The Secretary shall, to
3 the extent provided in advance in appropriation
4 Acts, pay such amounts so determined to the insurer
5 designated by the Secretary.

6 “(3) ASSOCIATION HEALTH PLAN FUND.—

7 “(A) IN GENERAL.—There is established
8 on the books of the Treasury a fund to be
9 known as the ‘Association Health Plan Fund’.
10 The Fund shall be available for making pay-
11 ments pursuant to paragraph (2). The Fund
12 shall be credited with payments received pursu-
13 ant to paragraph (1)(A), penalties received pur-
14 suant to paragraph (1)(B); and earnings on in-
15 vestments of amounts of the Fund under sub-
16 paragraph (B).

17 “(B) INVESTMENT.—Whenever the Sec-
18 retary determines that the moneys of the fund
19 are in excess of current needs, the Secretary
20 may request the investment of such amounts as
21 the Secretary determines advisable by the Sec-
22 retary of the Treasury in obligations issued or
23 guaranteed by the United States.

24 “(g) EXCESS/STOP LOSS INSURANCE.—For purposes
25 of this section—

1 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
2 ANCE.—The term ‘aggregate excess/stop loss insur-
3 ance’ means, in connection with an association
4 health plan, a contract—

5 “(A) under which an insurer (meeting such
6 minimum standards as the applicable authority
7 may prescribe by regulation) provides for pay-
8 ment to the plan with respect to aggregate
9 claims under the plan in excess of an amount
10 or amounts specified in such contract;

11 “(B) which is guaranteed renewable; and

12 “(C) which allows for payment of pre-
13 miums by any third party on behalf of the in-
14 sured plan.

15 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
16 ANCE.—The term ‘specific excess/stop loss insur-
17 ance’ means, in connection with an association
18 health plan, a contract—

19 “(A) under which an insurer (meeting such
20 minimum standards as the applicable authority
21 may prescribe by regulation) provides for pay-
22 ment to the plan with respect to claims under
23 the plan in connection with a covered individual
24 in excess of an amount or amounts specified in

1 such contract in connection with such covered
2 individual;

3 “(B) which is guaranteed renewable; and

4 “(C) which allows for payment of pre-
5 miums by any third party on behalf of the in-
6 sured plan.

7 “(h) INDEMNIFICATION INSURANCE.—For purposes
8 of this section, the term ‘indemnification insurance’
9 means, in connection with an association health plan, a
10 contract—

11 “(1) under which an insurer (meeting such min-
12 imum standards as the applicable authority may pre-
13 scribe by regulation) provides for payment to the
14 plan with respect to claims under the plan which the
15 plan is unable to satisfy by reason of a termination
16 pursuant to section 809(b) (relating to mandatory
17 termination);

18 “(2) which is guaranteed renewable and
19 noncancellable for any reason (except as the applica-
20 ble authority may prescribe by regulation); and

21 “(3) which allows for payment of premiums by
22 any third party on behalf of the insured plan.

23 “(i) RESERVES.—For purposes of this section, the
24 term ‘reserves’ means, in connection with an association
25 health plan, plan assets which meet the fiduciary stand-

1 ards under part 4 and such additional requirements re-
2 garding liquidity as the applicable authority may prescribe
3 by regulation.

4 “(j) SOLVENCY STANDARDS WORKING GROUP.—

5 “(1) IN GENERAL.—Within 90 days after the
6 date of the enactment of the Making Health Care
7 More Affordable Act of 2008, the applicable author-
8 ity shall establish a Solvency Standards Working
9 Group. In prescribing the initial regulations under
10 this section, the applicable authority shall take into
11 account the recommendations of such Working
12 Group.

13 “(2) MEMBERSHIP.—The Working Group shall
14 consist of not more than 15 members appointed by
15 the applicable authority. The applicable authority
16 shall include among persons invited to membership
17 on the Working Group at least one of each of the
18 following:

19 “(A) a representative of the National Asso-
20 ciation of Insurance Commissioners;

21 “(B) a representative of the American
22 Academy of Actuaries;

23 “(C) a representative of the State govern-
24 ments, or their interests;

1 “(D) a representative of existing self-in-
2 sured arrangements, or their interests;

3 “(E) a representative of associations of the
4 type referred to in section 801(b)(1), or their
5 interests; and

6 “(F) a representative of multiemployer
7 plans that are group health plans, or their in-
8 terests.

9 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
10 **LATED REQUIREMENTS.**

11 “(a) **FILING FEE.**—Under the procedure prescribed
12 pursuant to section 802(a), an association health plan
13 shall pay to the applicable authority at the time of filing
14 an application for certification under this part a filing fee
15 in the amount of \$5,000, which shall be available in the
16 case of the Secretary, to the extent provided in appropria-
17 tion Acts, for the sole purpose of administering the certifi-
18 cation procedures applicable with respect to association
19 health plans.

20 “(b) **INFORMATION TO BE INCLUDED IN APPLICA-**
21 **TION FOR CERTIFICATION.**—An application for certifi-
22 cation under this part meets the requirements of this sec-
23 tion only if it includes, in a manner and form which shall
24 be prescribed by the applicable authority by regulation, at
25 least the following information:

1 “(1) IDENTIFYING INFORMATION.—The names
2 and addresses of—

3 “(A) the sponsor; and

4 “(B) the members of the board of trustees
5 of the plan.

6 “(2) STATES IN WHICH PLAN INTENDS TO DO
7 BUSINESS.—The States in which participants and
8 beneficiaries under the plan are to be located and
9 the number of them expected to be located in each
10 such State.

11 “(3) BONDING REQUIREMENTS.—Evidence pro-
12 vided by the board of trustees that the bonding re-
13 quirements of section 412 will be met as of the date
14 of the application or (if later) commencement of op-
15 erations.

16 “(4) PLAN DOCUMENTS.—A copy of the docu-
17 ments governing the plan (including any bylaws and
18 trust agreements), the summary plan description,
19 and other material describing the benefits that will
20 be provided to participants and beneficiaries under
21 the plan.

22 “(5) AGREEMENTS WITH SERVICE PRO-
23 VIDERS.—A copy of any agreements between the
24 plan and contract administrators and other service
25 providers.

1 “(6) FUNDING REPORT.—In the case of asso-
2 ciation health plans providing benefits options in ad-
3 dition to health insurance coverage, a report setting
4 forth information with respect to such additional
5 benefit options determined as of a date within the
6 120-day period ending with the date of the applica-
7 tion, including the following:

8 “(A) RESERVES.—A statement, certified
9 by the board of trustees of the plan, and a
10 statement of actuarial opinion, signed by a
11 qualified actuary, that all applicable require-
12 ments of section 806 are or will be met in ac-
13 cordance with regulations which the applicable
14 authority shall prescribe.

15 “(B) ADEQUACY OF CONTRIBUTION
16 RATES.—A statement of actuarial opinion,
17 signed by a qualified actuary, which sets forth
18 a description of the extent to which contribution
19 rates are adequate to provide for the payment
20 of all obligations and the maintenance of re-
21 quired reserves under the plan for the 12-
22 month period beginning with such date within
23 such 120-day period, taking into account the
24 expected coverage and experience of the plan. If
25 the contribution rates are not fully adequate,

1 the statement of actuarial opinion shall indicate
2 the extent to which the rates are inadequate
3 and the changes needed to ensure adequacy.

4 “(C) CURRENT AND PROJECTED VALUE OF
5 ASSETS AND LIABILITIES.—A statement of ac-
6 tuarial opinion signed by a qualified actuary,
7 which sets forth the current value of the assets
8 and liabilities accumulated under the plan and
9 a projection of the assets, liabilities, income,
10 and expenses of the plan for the 12-month pe-
11 riod referred to in subparagraph (B). The in-
12 come statement shall identify separately the
13 plan’s administrative expenses and claims.

14 “(D) COSTS OF COVERAGE TO BE
15 CHARGED AND OTHER EXPENSES.—A state-
16 ment of the costs of coverage to be charged, in-
17 cluding an itemization of amounts for adminis-
18 tration, reserves, and other expenses associated
19 with the operation of the plan.

20 “(E) OTHER INFORMATION.—Any other
21 information as may be determined by the appli-
22 cable authority, by regulation, as necessary to
23 carry out the purposes of this part.

24 “(c) FILING NOTICE OF CERTIFICATION WITH
25 STATES.—A certification granted under this part to an

1 association health plan shall not be effective unless written
2 notice of such certification is filed with the applicable
3 State authority of each State in which at least 25 percent
4 of the participants and beneficiaries under the plan are
5 located. For purposes of this subsection, an individual
6 shall be considered to be located in the State in which a
7 known address of such individual is located or in which
8 such individual is employed.

9 “(d) NOTICE OF MATERIAL CHANGES.—In the case
10 of any association health plan certified under this part,
11 descriptions of material changes in any information which
12 was required to be submitted with the application for the
13 certification under this part shall be filed in such form
14 and manner as shall be prescribed by the applicable au-
15 thority by regulation. The applicable authority may re-
16 quire by regulation prior notice of material changes with
17 respect to specified matters which might serve as the basis
18 for suspension or revocation of the certification.

19 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
20 SOCIATION HEALTH PLANS.—An association health plan
21 certified under this part which provides benefit options in
22 addition to health insurance coverage for such plan year
23 shall meet the requirements of section 103 by filing an
24 annual report under such section which shall include infor-
25 mation described in subsection (b)(6) with respect to the

1 plan year and, notwithstanding section 104(a)(1)(A), shall
2 be filed with the applicable authority not later than 90
3 days after the close of the plan year (or on such later date
4 as may be prescribed by the applicable authority). The ap-
5 plicable authority may require by regulation such interim
6 reports as it considers appropriate.

7 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The
8 board of trustees of each association health plan which
9 provides benefits options in addition to health insurance
10 coverage and which is applying for certification under this
11 part or is certified under this part shall engage, on behalf
12 of all participants and beneficiaries, a qualified actuary
13 who shall be responsible for the preparation of the mate-
14 rials comprising information necessary to be submitted by
15 a qualified actuary under this part. The qualified actuary
16 shall utilize such assumptions and techniques as are nec-
17 essary to enable such actuary to form an opinion as to
18 whether the contents of the matters reported under this
19 part—

20 “(1) are in the aggregate reasonably related to
21 the experience of the plan and to reasonable expecta-
22 tions; and

23 “(2) represent such actuary’s best estimate of
24 anticipated experience under the plan.

1 The opinion by the qualified actuary shall be made with
2 respect to, and shall be made a part of, the annual report.

3 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
4 **MINATION.**

5 “Except as provided in section 809(b), an association
6 health plan which is or has been certified under this part
7 may terminate (upon or at any time after cessation of ac-
8 cruals in benefit liabilities) only if the board of trustees,
9 not less than 60 days before the proposed termination
10 date—

11 “(1) provides to the participants and bene-
12 ficiaries a written notice of intent to terminate stat-
13 ing that such termination is intended and the pro-
14 posed termination date;

15 “(2) develops a plan for winding up the affairs
16 of the plan in connection with such termination in
17 a manner which will result in timely payment of all
18 benefits for which the plan is obligated; and

19 “(3) submits such plan in writing to the appli-
20 cable authority.

21 Actions required under this section shall be taken in such
22 form and manner as may be prescribed by the applicable
23 authority by regulation.

1 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
2 **NATION.**

3 “(a) ACTIONS TO AVOID DEPLETION OF RE-
4 SERVES.—An association health plan which is certified
5 under this part and which provides benefits other than
6 health insurance coverage shall continue to meet the re-
7 quirements of section 806, irrespective of whether such
8 certification continues in effect. The board of trustees of
9 such plan shall determine quarterly whether the require-
10 ments of section 806 are met. In any case in which the
11 board determines that there is reason to believe that there
12 is or will be a failure to meet such requirements, or the
13 applicable authority makes such a determination and so
14 notifies the board, the board shall immediately notify the
15 qualified actuary engaged by the plan, and such actuary
16 shall, not later than the end of the next following month,
17 make such recommendations to the board for corrective
18 action as the actuary determines necessary to ensure com-
19 pliance with section 806. Not later than 30 days after re-
20 ceiving from the actuary recommendations for corrective
21 actions, the board shall notify the applicable authority (in
22 such form and manner as the applicable authority may
23 prescribe by regulation) of such recommendations of the
24 actuary for corrective action, together with a description
25 of the actions (if any) that the board has taken or plans
26 to take in response to such recommendations. The board

1 shall thereafter report to the applicable authority, in such
2 form and frequency as the applicable authority may speci-
3 fy to the board, regarding corrective action taken by the
4 board until the requirements of section 806 are met.

5 “(b) MANDATORY TERMINATION.—In any case in
6 which—

7 “(1) the applicable authority has been notified
8 under subsection (a) (or by an issuer of excess/stop
9 loss insurance or indemnity insurance pursuant to
10 section 806(a)) of a failure of an association health
11 plan which is or has been certified under this part
12 and is described in section 806(a)(2) to meet the re-
13 quirements of section 806 and has not been notified
14 by the board of trustees of the plan that corrective
15 action has restored compliance with such require-
16 ments; and

17 “(2) the applicable authority determines that
18 there is a reasonable expectation that the plan will
19 continue to fail to meet the requirements of section
20 806,

21 the board of trustees of the plan shall, at the direction
22 of the applicable authority, terminate the plan and, in the
23 course of the termination, take such actions as the appli-
24 cable authority may require, including satisfying any
25 claims referred to in section 806(a)(2)(B)(iii) and recov-

1 ering for the plan any liability under subsection
2 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
3 that the affairs of the plan will be, to the maximum extent
4 possible, wound up in a manner which will result in timely
5 provision of all benefits for which the plan is obligated.

6 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
7 **VENT ASSOCIATION HEALTH PLANS PRO-**
8 **VIDING HEALTH BENEFITS IN ADDITION TO**
9 **HEALTH INSURANCE COVERAGE.**

10 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
11 INSOLVENT PLANS.—Whenever the Secretary determines
12 that an association health plan which is or has been cer-
13 tified under this part and which is described in section
14 806(a)(2) will be unable to provide benefits when due or
15 is otherwise in a financially hazardous condition, as shall
16 be defined by the Secretary by regulation, the Secretary
17 shall, upon notice to the plan, apply to the appropriate
18 United States district court for appointment of the Sec-
19 retary as trustee to administer the plan for the duration
20 of the insolvency. The plan may appear as a party and
21 other interested persons may intervene in the proceedings
22 at the discretion of the court. The court shall appoint such
23 Secretary trustee if the court determines that the trustee-
24 ship is necessary to protect the interests of the partici-
25 pants and beneficiaries or providers of medical care or to

1 avoid any unreasonable deterioration of the financial con-
2 dition of the plan. The trusteeship of such Secretary shall
3 continue until the conditions described in the first sen-
4 tence of this subsection are remedied or the plan is termi-
5 nated.

6 “(b) POWERS AS TRUSTEE.—The Secretary, upon
7 appointment as trustee under subsection (a), shall have
8 the power—

9 “(1) to do any act authorized by the plan, this
10 title, or other applicable provisions of law to be done
11 by the plan administrator or any trustee of the plan;

12 “(2) to require the transfer of all (or any part)
13 of the assets and records of the plan to the Sec-
14 retary as trustee;

15 “(3) to invest any assets of the plan which the
16 Secretary holds in accordance with the provisions of
17 the plan, regulations prescribed by the Secretary,
18 and applicable provisions of law;

19 “(4) to require the sponsor, the plan adminis-
20 trator, any participating employer, and any employee
21 organization representing plan participants to fur-
22 nish any information with respect to the plan which
23 the Secretary as trustee may reasonably need in
24 order to administer the plan;

1 “(5) to collect for the plan any amounts due the
2 plan and to recover reasonable expenses of the trust-
3 eeship;

4 “(6) to commence, prosecute, or defend on be-
5 half of the plan any suit or proceeding involving the
6 plan;

7 “(7) to issue, publish, or file such notices, state-
8 ments, and reports as may be required by the Sec-
9 retary by regulation or required by any order of the
10 court;

11 “(8) to terminate the plan (or provide for its
12 termination in accordance with section 809(b)) and
13 liquidate the plan assets, to restore the plan to the
14 responsibility of the sponsor, or to continue the
15 trusteeship;

16 “(9) to provide for the enrollment of plan par-
17 ticipants and beneficiaries under appropriate cov-
18 erage options; and

19 “(10) to do such other acts as may be nec-
20 essary to comply with this title or any order of the
21 court and to protect the interests of plan partici-
22 pants and beneficiaries and providers of medical
23 care.

1 “(c) NOTICE OF APPOINTMENT.—As soon as prac-
2 ticable after the Secretary’s appointment as trustee, the
3 Secretary shall give notice of such appointment to—

4 “(1) the sponsor and plan administrator;

5 “(2) each participant;

6 “(3) each participating employer; and

7 “(4) if applicable, each employee organization
8 which, for purposes of collective bargaining, rep-
9 resents plan participants.

10 “(d) ADDITIONAL DUTIES.—Except to the extent in-
11 consistent with the provisions of this title, or as may be
12 otherwise ordered by the court, the Secretary, upon ap-
13 pointment as trustee under this section, shall be subject
14 to the same duties as those of a trustee under section 704
15 of title 11, United States Code, and shall have the duties
16 of a fiduciary for purposes of this title.

17 “(e) OTHER PROCEEDINGS.—An application by the
18 Secretary under this subsection may be filed notwith-
19 standing the pendency in the same or any other court of
20 any bankruptcy, mortgage foreclosure, or equity receiver-
21 ship proceeding, or any proceeding to reorganize, conserve,
22 or liquidate such plan or its property, or any proceeding
23 to enforce a lien against property of the plan.

24 “(f) JURISDICTION OF COURT.—

1 “(1) IN GENERAL.—Upon the filing of an appli-
2 cation for the appointment as trustee or the issuance
3 of a decree under this section, the court to which the
4 application is made shall have exclusive jurisdiction
5 of the plan involved and its property wherever lo-
6 cated with the powers, to the extent consistent with
7 the purposes of this section, of a court of the United
8 States having jurisdiction over cases under chapter
9 11 of title 11, United States Code. Pending an adju-
10 dication under this section such court shall stay, and
11 upon appointment by it of the Secretary as trustee,
12 such court shall continue the stay of, any pending
13 mortgage foreclosure, equity receivership, or other
14 proceeding to reorganize, conserve, or liquidate the
15 plan, the sponsor, or property of such plan or spon-
16 sor, and any other suit against any receiver, conser-
17 vator, or trustee of the plan, the sponsor, or prop-
18 erty of the plan or sponsor. Pending such adjudica-
19 tion and upon the appointment by it of the Sec-
20 retary as trustee, the court may stay any proceeding
21 to enforce a lien against property of the plan or the
22 sponsor or any other suit against the plan or the
23 sponsor.

24 “(2) VENUE.—An action under this section
25 may be brought in the judicial district where the

1 sponsor or the plan administrator resides or does
2 business or where any asset of the plan is situated.
3 A district court in which such action is brought may
4 issue process with respect to such action in any
5 other judicial district.

6 “(g) PERSONNEL.—In accordance with regulations
7 which shall be prescribed by the Secretary, the Secretary
8 shall appoint, retain, and compensate accountants, actu-
9 aries, and other professional service personnel as may be
10 necessary in connection with the Secretary’s service as
11 trustee under this section.

12 **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

13 “(a) IN GENERAL.—Notwithstanding section 514, a
14 State may impose by law a contribution tax on an associa-
15 tion health plan described in section 806(a)(2), if the plan
16 commenced operations in such State after the date of the
17 enactment of the Making Health Care More Affordable
18 Act of 2008.

19 “(b) CONTRIBUTION TAX.—For purposes of this sec-
20 tion, the term ‘contribution tax’ imposed by a State on
21 an association health plan means any tax imposed by such
22 State if—

23 “(1) such tax is computed by applying a rate to
24 the amount of premiums or contributions, with re-
25 spect to individuals covered under the plan who are

1 residents of such State, which are received by the
2 plan from participating employers located in such
3 State or from such individuals;

4 “(2) the rate of such tax does not exceed the
5 rate of any tax imposed by such State on premiums
6 or contributions received by insurers or health main-
7 tenance organizations for health insurance coverage
8 offered in such State in connection with a group
9 health plan;

10 “(3) such tax is otherwise nondiscriminatory;
11 and

12 “(4) the amount of any such tax assessed on
13 the plan is reduced by the amount of any tax or as-
14 sessment otherwise imposed by the State on pre-
15 miums, contributions, or both received by insurers or
16 health maintenance organizations for health insur-
17 ance coverage, aggregate excess/stop loss insurance
18 (as defined in section 806(g)(1)), specific excess/stop
19 loss insurance (as defined in section 806(g)(2)),
20 other insurance related to the provision of medical
21 care under the plan, or any combination thereof pro-
22 vided by such insurers or health maintenance organi-
23 zations in such State in connection with such plan.

24 **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

25 “(a) DEFINITIONS.—For purposes of this part—

1 “(1) GROUP HEALTH PLAN.—The term ‘group
2 health plan’ has the meaning provided in section
3 733(a)(1) (after applying subsection (b) of this sec-
4 tion).

5 “(2) MEDICAL CARE.—The term ‘medical care’
6 has the meaning provided in section 733(a)(2).

7 “(3) HEALTH INSURANCE COVERAGE.—The
8 term ‘health insurance coverage’ has the meaning
9 provided in section 733(b)(1).

10 “(4) HEALTH INSURANCE ISSUER.—The term
11 ‘health insurance issuer’ has the meaning provided
12 in section 733(b)(2).

13 “(5) APPLICABLE AUTHORITY.—The term ‘ap-
14 plicable authority’ means the Secretary, except that,
15 in connection with any exercise of the Secretary’s
16 authority regarding which the Secretary is required
17 under section 506(d) to consult with a State, such
18 term means the Secretary, in consultation with such
19 State.

20 “(6) HEALTH STATUS-RELATED FACTOR.—The
21 term ‘health status-related factor’ has the meaning
22 provided in section 733(d)(2).

23 “(7) INDIVIDUAL MARKET.—

24 “(A) IN GENERAL.—The term ‘individual
25 market’ means the market for health insurance

1 coverage offered to individuals other than in
2 connection with a group health plan.

3 “(B) TREATMENT OF VERY SMALL
4 GROUPS.—

5 “(i) IN GENERAL.—Subject to clause
6 (ii), such term includes coverage offered in
7 connection with a group health plan that
8 has fewer than 2 participants as current
9 employees or participants described in sec-
10 tion 732(d)(3) on the first day of the plan
11 year.

12 “(ii) STATE EXCEPTION.—Clause (I)
13 shall not apply in the case of health insur-
14 ance coverage offered in a State if such
15 State regulates the coverage described in
16 such clause in the same manner and to the
17 same extent as coverage in the small group
18 market (as defined in section 2791(e)(5) of
19 the Public Health Service Act) is regulated
20 by such State.

21 “(8) PARTICIPATING EMPLOYER.—The term
22 ‘participating employer’ means, in connection with
23 an association health plan, any employer, if any indi-
24 vidual who is an employee of such employer, a part-
25 ner in such employer, or a self-employed individual

1 who is such employer (or any dependent, as defined
2 under the terms of the plan, of such individual) is
3 or was covered under such plan in connection with
4 the status of such individual as such an employee,
5 partner, or self-employed individual in relation to the
6 plan.

7 “(9) APPLICABLE STATE AUTHORITY.—The
8 term ‘applicable State authority’ means, with respect
9 to a health insurance issuer in a State, the State in-
10 surance commissioner or official or officials des-
11 ignated by the State to enforce the requirements of
12 title XXVII of the Public Health Service Act for the
13 State involved with respect to such issuer.

14 “(10) QUALIFIED ACTUARY.—The term ‘quali-
15 fied actuary’ means an individual who is a member
16 of the American Academy of Actuaries.

17 “(11) AFFILIATED MEMBER.—The term ‘affili-
18 ated member’ means, in connection with a sponsor—

19 “(A) a person who is otherwise eligible to
20 be a member of the sponsor but who elects an
21 affiliated status with the sponsor,

22 “(B) in the case of a sponsor with mem-
23 bers which consist of associations, a person who
24 is a member of any such association and elects
25 an affiliated status with the sponsor, or

1 “(C) in the case of an association health
2 plan in existence on the date of the enactment
3 of the Making Health Care More Affordable
4 Act of 2008, a person eligible to be a member
5 of the sponsor or one of its member associa-
6 tions.

7 “(12) LARGE EMPLOYER.—The term ‘large em-
8 ployer’ means, in connection with a group health
9 plan with respect to a plan year, an employer who
10 employed an average of at least 51 employees on
11 business days during the preceding calendar year
12 and who employs at least 2 employees on the first
13 day of the plan year.

14 “(13) SMALL EMPLOYER.—The term ‘small em-
15 ployer’ means, in connection with a group health
16 plan with respect to a plan year, an employer who
17 is not a large employer.

18 “(b) RULES OF CONSTRUCTION.—

19 “(1) EMPLOYERS AND EMPLOYEES.—For pur-
20 poses of determining whether a plan, fund, or pro-
21 gram is an employee welfare benefit plan which is an
22 association health plan, and for purposes of applying
23 this title in connection with such plan, fund, or pro-
24 gram so determined to be such an employee welfare
25 benefit plan—

1 “(A) in the case of a partnership, the term
2 ‘employer’ (as defined in section 3(5)) includes
3 the partnership in relation to the partners, and
4 the term ‘employee’ (as defined in section 3(6))
5 includes any partner in relation to the partner-
6 ship; and

7 “(B) in the case of a self-employed indi-
8 vidual, the term ‘employer’ (as defined in sec-
9 tion 3(5)) and the term ‘employee’ (as defined
10 in section 3(6)) shall include such individual.

11 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
12 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
13 case of any plan, fund, or program which was estab-
14 lished or is maintained for the purpose of providing
15 medical care (through the purchase of insurance or
16 otherwise) for employees (or their dependents) cov-
17 ered thereunder and which demonstrates to the Sec-
18 retary that all requirements for certification under
19 this part would be met with respect to such plan,
20 fund, or program if such plan, fund, or program
21 were a group health plan, such plan, fund, or pro-
22 gram shall be treated for purposes of this title as an
23 employee welfare benefit plan on and after the date
24 of such demonstration.”.

1 (b) CONFORMING AMENDMENTS TO PREEMPTION
2 RULES.—

3 (1) Section 514(b)(6) of such Act (29 U.S.C.
4 1144(b)(6)) is amended by adding at the end the
5 following new subparagraph:

6 “(E) The preceding subparagraphs of this paragraph
7 do not apply with respect to any State law in the case
8 of an association health plan which is certified under part
9 8.”.

10 (2) Section 514 of such Act (29 U.S.C. 1144)
11 is amended—

12 (A) in subsection (b)(4), by striking “Sub-
13 section (a)” and inserting “Subsections (a) and
14 (d)”;

15 (B) in subsection (b)(5), by striking “sub-
16 section (a)” in subparagraph (A) and inserting
17 “subsection (a) of this section and subsections
18 (a)(2)(B) and (b) of section 805”, and by strik-
19 ing “subsection (a)” in subparagraph (B) and
20 inserting “subsection (a) of this section or sub-
21 section (a)(2)(B) or (b) of section 805”;

22 (C) by redesignating subsection (d) as sub-
23 section (e); and

24 (D) by inserting after subsection (c) the
25 following new subsection:

1 “(d)(1) Except as provided in subsection (b)(4), the
2 provisions of this title shall supersede any and all State
3 laws insofar as they may now or hereafter preclude, or
4 have the effect of precluding, a health insurance issuer
5 from offering health insurance coverage in connection with
6 an association health plan which is certified under part
7 8.

8 “(2) Except as provided in paragraphs (4) and (5)
9 of subsection (b) of this section—

10 “(A) In any case in which health insurance cov-
11 erage of any policy type is offered under an associa-
12 tion health plan certified under part 8 to a partici-
13 pating employer operating in such State, the provi-
14 sions of this title shall supersede any and all laws
15 of such State insofar as they may preclude a health
16 insurance issuer from offering health insurance cov-
17 erage of the same policy type to other employers op-
18 erating in the State which are eligible for coverage
19 under such association health plan, whether or not
20 such other employers are participating employers in
21 such plan.

22 “(B) In any case in which health insurance cov-
23 erage of any policy type is offered in a State under
24 an association health plan certified under part 8 and
25 the filing, with the applicable State authority (as de-

1 fined in section 812(a)(9)), of the policy form in
2 connection with such policy type is approved by such
3 State authority, the provisions of this title shall su-
4 percede any and all laws of any other State in which
5 health insurance coverage of such type is offered, in-
6 sofar as they may preclude, upon the filing in the
7 same form and manner of such policy form with the
8 applicable State authority in such other State, the
9 approval of the filing in such other State.

10 “(3) Nothing in subsection (b)(6)(E) or the preceding
11 provisions of this subsection shall be construed, with re-
12 spect to health insurance issuers or health insurance cov-
13 erage, to supersede or impair the law of any State—

14 “(A) providing solvency standards or similar
15 standards regarding the adequacy of insurer capital,
16 surplus, reserves, or contributions, or

17 “(B) relating to prompt payment of claims.

18 “(4) For additional provisions relating to association
19 health plans, see subsections (a)(2)(B) and (b) of section
20 805.

21 “(5) For purposes of this subsection, the term ‘asso-
22 ciation health plan’ has the meaning provided in section
23 801(a), and the terms ‘health insurance coverage’, ‘par-
24 ticipating employer’, and ‘health insurance issuer’ have

1 the meanings provided such terms in section 812, respec-
2 tively.”.

3 (3) Section 514(b)(6)(A) of such Act (29
4 U.S.C. 1144(b)(6)(A)) is amended—

5 (A) in clause (I)(II), by striking “and” at
6 the end;

7 (B) in clause (ii), by inserting “and which
8 does not provide medical care (within the mean-
9 ing of section 733(a)(2)),” after “arrange-
10 ment,”, and by striking “title.” and inserting
11 “title, and”; and

12 (C) by adding at the end the following new
13 clause:

14 “(iii) subject to subparagraph (E), in the case
15 of any other employee welfare benefit plan which is
16 a multiple employer welfare arrangement and which
17 provides medical care (within the meaning of section
18 733(a)(2)), any law of any State which regulates in-
19 surance may apply.”.

20 (4) Section 514(e) of such Act (as redesignated
21 by paragraph (2)(C)) is amended—

22 (A) by striking “Nothing” and inserting
23 “(1) Except as provided in paragraph (2), noth-
24 ing”; and

1 (B) by adding at the end the following new
2 paragraph:

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of the Making
5 Health Care More Affordable Act of 2008 shall be con-
6 strued to alter, amend, modify, invalidate, impair, or su-
7 percede any provision of this title, except by specific cross-
8 reference to the affected section.”.

9 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
10 (29 U.S.C. 102(16)(B)) is amended by adding at the end
11 the following new sentence: “Such term also includes a
12 person serving as the sponsor of an association health plan
13 under part 8.”.

14 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
15 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
16 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)
17 of such Act (29 U.S.C. 102(b)) is amended by adding at
18 the end the following: “An association health plan shall
19 include in its summary plan description, in connection
20 with each benefit option, a description of the form of sol-
21 vency or guarantee fund protection secured pursuant to
22 this Act or applicable State law, if any.”.

23 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is
24 amended by inserting “or part 8” after “this part”.

1 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
 2 CATION OF SELF-INSURED ASSOCIATION HEALTH
 3 PLANS.—Not later than January 1, 2012, the Secretary
 4 of Labor shall report to the Committee on Education and
 5 the Workforce of the House of Representatives and the
 6 Committee on Health, Education, Labor, and Pensions of
 7 the Senate the effect association health plans have had,
 8 if any, on reducing the number of uninsured individuals.

9 (g) CLERICAL AMENDMENT.—The table of contents
 10 in section 1 of the Employee Retirement Income Security
 11 Act of 1974 is amended by inserting after the item relat-
 12 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “801. Association health plans.
- “802. Certification of association health plans.
- “803. Requirements relating to sponsors and boards of trustees.
- “804. Participation and coverage requirements.
- “805. Other requirements relating to plan documents, contribution rates, and benefit options.
- “806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
- “807. Requirements for application and related requirements.
- “808. Notice requirements for voluntary termination.
- “809. Corrective actions and mandatory termination.
- “810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
- “811. State assessment authority.
- “812. Definitions and rules of construction.”.

13 **SEC. 202. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 14 **PLOYER ARRANGEMENTS.**

15 Section 3(40)(B) of the Employee Retirement Income
 16 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
 17 ed—

1 (1) in clause (I), by inserting after “control
2 group,” the following: “except that, in any case in
3 which the benefit referred to in subparagraph (A)
4 consists of medical care (as defined in section
5 812(a)(2)), two or more trades or businesses, wheth-
6 er or not incorporated, shall be deemed a single em-
7 ployer for any plan year of such plan, or any fiscal
8 year of such other arrangement, if such trades or
9 businesses are within the same control group during
10 such year or at any time during the preceding 1-year
11 period,”;

12 (2) in clause (iii), by striking “(iii) the deter-
13 mination” and inserting the following:

14 “(iii)(I) in any case in which the benefit re-
15 ferred to in subparagraph (A) consists of medical
16 care (as defined in section 812(a)(2)), the deter-
17 mination of whether a trade or business is under
18 ‘common control’ with another trade or business
19 shall be determined under regulations of the Sec-
20 retary applying principles consistent and coextensive
21 with the principles applied in determining whether
22 employees of two or more trades or businesses are
23 treated as employed by a single employer under sec-
24 tion 4001(b), except that, for purposes of this para-
25 graph, an interest of greater than 25 percent may

1 not be required as the minimum interest necessary
2 for common control, or

3 “(II) in any other case, the determination”;

4 (3) by redesignating clauses (iv) and (v) as
5 clauses (v) and (vi), respectively; and

6 (4) by inserting after clause (iii) the following
7 new clause:

8 “(iv) in any case in which the benefit referred
9 to in subparagraph (A) consists of medical care (as
10 defined in section 812(a)(2)), in determining, after
11 the application of clause (I), whether benefits are
12 provided to employees of two or more employers, the
13 arrangement shall be treated as having only one par-
14 ticipating employer if, after the application of clause
15 (I), the number of individuals who are employees
16 and former employees of any one participating em-
17 ployer and who are covered under the arrangement
18 is greater than 75 percent of the aggregate number
19 of all individuals who are employees or former em-
20 ployees of participating employers and who are cov-
21 ered under the arrangement,”.

22 **SEC. 203. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
23 **CIATION HEALTH PLANS.**

24 (a) **CRIMINAL PENALTIES FOR CERTAIN WILLFUL**
25 **MISREPRESENTATIONS.**—Section 501 of the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
2 is amended—

3 (1) by inserting “(a)” after “Sec. 501.”; and

4 (2) by adding at the end the following new sub-
5 section:

6 “(b) Any person who willfully falsely represents, to
7 any employee, any employee’s beneficiary, any employer,
8 the Secretary, or any State, a plan or other arrangement
9 established or maintained for the purpose of offering or
10 providing any benefit described in section 3(1) to employ-
11 ees or their beneficiaries as—

12 “(1) being an association health plan which has
13 been certified under part 8;

14 “(2) having been established or maintained
15 under or pursuant to one or more collective bar-
16 gaining agreements which are reached pursuant to
17 collective bargaining described in section 8(d) of the
18 National Labor Relations Act (29 U.S.C. 158(d)) or
19 paragraph Fourth of section 2 of the Railway Labor
20 Act (45 U.S.C. 152, paragraph Fourth) or which are
21 reached pursuant to labor-management negotiations
22 under similar provisions of State public employee re-
23 lations laws; or

24 “(3) being a plan or arrangement described in
25 section 3(40)(A)(I),

1 shall, upon conviction, be imprisoned not more than 5
2 years, be fined under title 18, United States Code, or
3 both.”.

4 (b) CEASE ACTIVITIES ORDERS.—Section 502 of
5 such Act (29 U.S.C. 1132) is amended by adding at the
6 end the following new subsection:

7 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
8 SIST ORDERS.—

9 “(1) IN GENERAL.—Subject to paragraph (2),
10 upon application by the Secretary showing the oper-
11 ation, promotion, or marketing of an association
12 health plan (or similar arrangement providing bene-
13 fits consisting of medical care (as defined in section
14 733(a)(2))) that—

15 “(A) is not certified under part 8, is sub-
16 ject under section 514(b)(6) to the insurance
17 laws of any State in which the plan or arrange-
18 ment offers or provides benefits, and is not li-
19 censed, registered, or otherwise approved under
20 the insurance laws of such State; or

21 “(B) is an association health plan certified
22 under part 8 and is not operating in accordance
23 with the requirements under part 8 for such
24 certification,

1 a district court of the United States shall enter an
2 order requiring that the plan or arrangement cease
3 activities.

4 “(2) EXCEPTION.—Paragraph (1) shall not
5 apply in the case of an association health plan or
6 other arrangement if the plan or arrangement shows
7 that—

8 “(A) all benefits under it referred to in
9 paragraph (1) consist of health insurance cov-
10 erage; and

11 “(B) with respect to each State in which
12 the plan or arrangement offers or provides ben-
13 efits, the plan or arrangement is operating in
14 accordance with applicable State laws that are
15 not superseded under section 514.

16 “(3) ADDITIONAL EQUITABLE RELIEF.—The
17 court may grant such additional equitable relief, in-
18 cluding any relief available under this title, as it
19 deems necessary to protect the interests of the pub-
20 lic and of persons having claims for benefits against
21 the plan.”.

22 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
23 Section 503 of such Act (29 U.S.C. 1133) is amended by
24 inserting “(a) IN GENERAL.—” before “In accordance”,
25 and by adding at the end the following new subsection:

1 “(b) ASSOCIATION HEALTH PLANS.—The terms of
2 each association health plan which is or has been certified
3 under part 8 shall require the board of trustees or the
4 named fiduciary (as applicable) to ensure that the require-
5 ments of this section are met in connection with claims
6 filed under the plan.”.

7 **SEC. 204. COOPERATION BETWEEN FEDERAL AND STATE**
8 **AUTHORITIES.**

9 Section 506 of the Employee Retirement Income Se-
10 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
11 at the end the following new subsection:

12 “(d) CONSULTATION WITH STATES WITH RESPECT
13 TO ASSOCIATION HEALTH PLANS.—

14 “(1) AGREEMENTS WITH STATES.—The Sec-
15 retary shall consult with the State recognized under
16 paragraph (2) with respect to an association health
17 plan regarding the exercise of—

18 “(A) the Secretary’s authority under sec-
19 tions 502 and 504 to enforce the requirements
20 for certification under part 8; and

21 “(B) the Secretary’s authority to certify
22 association health plans under part 8 in accord-
23 ance with regulations of the Secretary applica-
24 ble to certification under part 8.

1 “(2) RECOGNITION OF PRIMARY DOMICILE
2 STATE.—In carrying out paragraph (1), the Sec-
3 retary shall ensure that only one State will be recog-
4 nized, with respect to any particular association
5 health plan, as the State with which consultation is
6 required. In carrying out this paragraph—

7 “(A) in the case of a plan which provides
8 health insurance coverage (as defined in section
9 812(a)(3)), such State shall be the State with
10 which filing and approval of a policy type of-
11 fered by the plan was initially obtained, and

12 “(B) in any other case, the Secretary shall
13 take into account the places of residence of the
14 participants and beneficiaries under the plan
15 and the State in which the trust is main-
16 tained.”.

17 **SEC. 205. EFFECTIVE DATE AND TRANSITIONAL AND**
18 **OTHER RULES.**

19 (a) EFFECTIVE DATE.—The amendments made by
20 this title shall take effect 1 year after the date of the en-
21 actment of this Act. The Secretary of Labor shall first
22 issue all regulations necessary to carry out the amend-
23 ments made by this title within 1 year after the date of
24 the enactment of this Act.

1 (b) TREATMENT OF CERTAIN EXISTING HEALTH
2 BENEFITS PROGRAMS.—

3 (1) IN GENERAL.—In any case in which, as of
4 the date of the enactment of this Act, an arrange-
5 ment is maintained in a State for the purpose of
6 providing benefits consisting of medical care for the
7 employees and beneficiaries of its participating em-
8 ployers, at least 200 participating employers make
9 contributions to such arrangement, such arrange-
10 ment has been in existence for at least 10 years, and
11 such arrangement is licensed under the laws of one
12 or more States to provide such benefits to its par-
13 ticipating employers, upon the filing with the appli-
14 cable authority (as defined in section 812(a)(5) of
15 the Employee Retirement Income Security Act of
16 1974 (as amended by this subtitle)) by the arrange-
17 ment of an application for certification of the ar-
18 rangement under part 8 of subtitle B of title I of
19 such Act—

20 (A) such arrangement shall be deemed to
21 be a group health plan for purposes of title I
22 of such Act;

23 (B) the requirements of sections 801(a)
24 and 803(a) of the Employee Retirement Income

1 Security Act of 1974 shall be deemed met with
2 respect to such arrangement;

3 (C) the requirements of section 803(b) of
4 such Act shall be deemed met, if the arrange-
5 ment is operated by a board of directors
6 which—

7 (i) is elected by the participating em-
8 ployers, with each employer having one
9 vote; and

10 (ii) has complete fiscal control over
11 the arrangement and which is responsible
12 for all operations of the arrangement;

13 (D) the requirements of section 804(a) of
14 such Act shall be deemed met with respect to
15 such arrangement; and

16 (E) the arrangement may be certified by
17 any applicable authority with respect to its op-
18 erations in any State only if it operates in such
19 State on the date of certification.

20 The provisions of this subsection shall cease to apply
21 with respect to any such arrangement at such time
22 after the date of the enactment of this Act as the
23 applicable requirements of this subsection are not
24 met with respect to such arrangement.

1 (2) DEFINITIONS.—For purposes of this sub-
 2 section, the terms “group health plan”, “medical
 3 care”, and “participating employer” shall have the
 4 meanings provided in section 812 of the Employee
 5 Retirement Income Security Act of 1974, except
 6 that the reference in paragraph (7) of such section
 7 to an “association health plan” shall be deemed a
 8 reference to an arrangement referred to in this sub-
 9 section.

10 **TITLE III—PURCHASE HEALTH**
 11 **INSURANCE ACROSS STATE**
 12 **LINES**

13 **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**
 14 **HEALTH INSURANCE COVERAGE.**

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

18 “PART D—COOPERATIVE GOVERNING OF INDIVIDUAL
 19 HEALTH INSURANCE COVERAGE

20 “DEFINITIONS

21 “SEC. 2795.

22 “In this part:

23 “(1) PRIMARY STATE.—The term ‘primary
 24 State’ means, with respect to individual health insur-
 25 ance coverage offered by a health insurance issuer,

1 the State designated by the issuer as the State
2 whose covered laws shall govern the health insurance
3 issuer in the sale of such coverage under this part.
4 An issuer, with respect to a particular policy, may
5 only designate one such State as its primary State
6 with respect to all such coverage it offers. Such an
7 issuer may not change the designated primary State
8 with respect to individual health insurance coverage
9 once the policy is issued, except that such a change
10 may be made upon renewal of the policy. With re-
11 spect to such designated State, the issuer is deemed
12 to be doing business in that State.

13 “(2) SECONDARY STATE.—The term ‘secondary
14 State’ means, with respect to individual health insur-
15 ance coverage offered by a health insurance issuer,
16 any State that is not the primary State. In the case
17 of a health insurance issuer that is selling a policy
18 in, or to a resident of, a secondary State, the issuer
19 is deemed to be doing business in that secondary
20 State.

21 “(3) HEALTH INSURANCE ISSUER.—The term
22 ‘health insurance issuer’ has the meaning given such
23 term in section 2791(b)(2), except that such an
24 issuer must be licensed in the primary State and be

1 qualified to sell individual health insurance coverage
2 in that State.

3 “(4) INDIVIDUAL HEALTH INSURANCE COV-
4 ERAGE.—The term ‘individual health insurance cov-
5 erage’ means health insurance coverage offered in
6 the individual market, as defined in section
7 2791(e)(1).

8 “(5) APPLICABLE STATE AUTHORITY.—The
9 term ‘applicable State authority’ means, with respect
10 to a health insurance issuer in a State, the State in-
11 surance commissioner or official or officials des-
12 ignated by the State to enforce the requirements of
13 this title for the State with respect to the issuer.

14 “(6) HAZARDOUS FINANCIAL CONDITION.—The
15 term ‘hazardous financial condition’ means that,
16 based on its present or reasonably anticipated finan-
17 cial condition, a health insurance issuer is unlikely
18 to be able—

19 “(A) to meet obligations to policyholders
20 with respect to known claims and reasonably
21 anticipated claims; or

22 “(B) to pay other obligations in the normal
23 course of business.

24 “(7) COVERED LAWS.—

1 “(A) IN GENERAL.—The term ‘covered
2 laws’ means the laws, rules, regulations, agree-
3 ments, and orders governing the insurance busi-
4 ness pertaining to—

5 “(i) individual health insurance cov-
6 erage issued by a health insurance issuer;

7 “(ii) the offer, sale, rating (including
8 medical underwriting), renewal, and
9 issuance of individual health insurance cov-
10 erage to an individual;

11 “(iii) the provision to an individual in
12 relation to individual health insurance cov-
13 erage of health care and insurance related
14 services;

15 “(iv) the provision to an individual in
16 relation to individual health insurance cov-
17 erage of management, operations, and in-
18 vestment activities of a health insurance
19 issuer; and

20 “(v) the provision to an individual in
21 relation to individual health insurance cov-
22 erage of loss control and claims adminis-
23 tration for a health insurance issuer with
24 respect to liability for which the issuer pro-
25 vides insurance.

1 “(B) EXCEPTION.—Such term does not in-
2 clude any law, rule, regulation, agreement, or
3 order governing the use of care or cost manage-
4 ment techniques, including any requirement re-
5 lated to provider contracting, network access or
6 adequacy, health care data collection, or quality
7 assurance.

8 “(8) STATE.—The term ‘State’ means the 50
9 States and includes the District of Columbia, Puerto
10 Rico, the Virgin Islands, Guam, American Samoa,
11 and the Northern Mariana Islands.

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

15 “(A) Knowingly misrepresenting to claim-
16 ants and insured individuals relevant facts or
17 policy provisions relating to coverage at issue.

18 “(B) Failing to acknowledge with reason-
19 able promptness pertinent communications with
20 respect to claims arising under policies.

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

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

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

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

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

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

23 “(I) Attempting to settle or settling claims
24 on the basis of an application that was materi-

1 ally altered without notice to, or knowledge or
2 consent of, the insured.

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

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

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

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

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

24 “(ii) The rating of an insurance policy
25 or reinsurance contract.

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

4 “(iv) Premiums paid on an insurance
5 policy or reinsurance contract.

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

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

12 “(vii) The financial condition of an in-
13 surer or reinsurer.

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

19 “(ix) The issuance of written evidence
20 of insurance.

21 “(x) The reinstatement of an insur-
22 ance policy.

23 “(B) Solicitation or acceptance of new or
24 renewal insurance risks on behalf of an insurer
25 reinsurer or other person engaged in the busi-

1 ness of insurance by a person who knows or
2 should know that the insurer or other person
3 responsible for the risk is insolvent at the time
4 of the transaction.

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

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

13 “APPLICATION OF LAW

14 “SEC. 2796.

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

21 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
22 ONDARY STATE.—Except as provided in this section, a
23 health insurance issuer with respect to its offer, sale, rat-
24 ing (including medical underwriting), renewal, and
25 issuance of individual health insurance coverage in any
26 secondary State is exempt from any covered laws of the

1 secondary State (and any rules, regulations, agreements,
2 or orders sought or issued by such State under or related
3 to such covered laws) to the extent that such laws would—

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

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

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

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

22 “(i) the State insurance commissioner
23 of the primary State has not done an ex-
24 amination within the period recommended

1 by the National Association of Insurance
2 Commissioners; and

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

9 “(D) to comply with a lawful order
10 issued—

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

16 “(ii) in a voluntary dissolution pro-
17 ceeding;

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

23 “(F) to participate, on a nondiscriminatory
24 basis, in any insurance insolvency guaranty as-
25 sociation or similar association to which a

1 health insurance issuer in the State is required
2 to belong;

3 “(G) to comply with any State law regard-
4 ing fraud and abuse (as defined in section
5 2795(10)), except that if the State seeks an in-
6 junction regarding the conduct described in this
7 subparagraph, such injunction must be obtained
8 from a court of competent jurisdiction;

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

12 “(I) to comply with the applicable require-
13 ments for independent review under section
14 2798 with respect to coverage offered in the
15 State;

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

20 “(3) otherwise discriminate against the issuer
21 issuing insurance in both the primary State and in
22 any secondary State.

23 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
24 health insurance issuer shall provide the following notice,
25 in 12-point bold type, in any insurance coverage offered

1 in a secondary State under this part by such a health in-
2 surance issuer and at renewal of the policy, with the 5
3 blank spaces therein being appropriately filled with the
4 name of the health insurance issuer, the name of primary
5 State, the name of the secondary State, the name of the
6 secondary State, and the name of the secondary State, re-
7 spectively, for the coverage concerned: ‘Notice: This policy
8 is issued by _____ and is governed
9 by the laws and regulations of the State of
10 _____, and it has met all the laws
11 of that State as determined by that State’s Department
12 of Insurance. This policy may be less expensive than oth-
13 ers because it is not subject to all of the insurance laws
14 and regulations of the State of
15 _____, including coverage of some
16 services or benefits mandated by the law of the State of
17 _____. Additionally, this policy is
18 not subject to all of the consumer protection laws or re-
19 strictions on rate changes of the State of
20 _____. As with all insurance prod-
21 ucts, before purchasing this policy, you should carefully
22 review the policy and determine what health care services
23 the policy covers and what benefits it provides, including
24 any exclusions, limitations, or conditions for such services
25 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 “PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE
17 ISSUER MAY SELL INTO SECONDARY STATES

18 “SEC. 2797.

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.

25 “INDEPENDENT EXTERNAL APPEALS PROCEDURES

26 “SEC. 2798.

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

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

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

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

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

5 “(A) each independent medical reviewer
6 meets the qualifications described in paragraphs
7 (2) and (3);

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

13 “(C) compensation provided by the issuer
14 to each reviewer is consistent with paragraph
15 (6).

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

20 “(A) is appropriately credentialed or li-
21 censed in 1 or more States to deliver health
22 care services; and

23 “(B) typically treats the condition, makes
24 the diagnosis, or provides the type of treatment
25 under review.

1 “(3) INDEPENDENCE.—

2 “(A) IN GENERAL.—Subject to subpara-
3 graph (B), each independent medical reviewer
4 in a case shall—

5 “(i) not be a related party (as defined
6 in paragraph (7));

7 “(ii) not have a material familial, fi-
8 nancial, or professional relationship with
9 such a party; and

10 “(iii) not otherwise have a conflict of
11 interest with such a party (as determined
12 under regulations).

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

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

19 “(I) a non-affiliated individual is
20 not reasonably available;

21 “(II) the affiliated individual is
22 not involved in the provision of items
23 or services in the case under review;

24 “(III) the fact of such an affili-
25 ation is disclosed to the issuer and the

1 enrollee (or authorized representative)
2 and neither party objects; and

3 “(IV) the affiliated individual is
4 not an employee of the issuer and
5 does not provide services exclusively or
6 primarily to or on behalf of the issuer;

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

15 “(iii) prohibit receipt of compensation
16 by an independent medical reviewer from
17 an entity if the compensation is provided
18 consistent with paragraph (6).

19 “(4) PRACTICING HEALTH CARE PROFESSIONAL
20 IN SAME FIELD.—

21 “(A) IN GENERAL.—In a case involving
22 treatment, or the provision of items or serv-
23 ices—

24 “(i) by a physician, a reviewer shall be
25 a practicing physician (allopathic or osteo-

1 pathic) of the same or similar specialty, as
2 a physician who, acting within the appro-
3 priate scope of practice within the State in
4 which the service is provided or rendered,
5 typically treats the condition, makes the
6 diagnosis, or provides the type of treat-
7 ment under review; or

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

20 “(B) PRACTICING DEFINED.—For pur-
21 poses of this paragraph, the term ‘practicing’
22 means, with respect to an individual who is a
23 physician or other health care professional, that
24 the individual provides health care services to

1 individual patients on average at least 2 days
2 per week.

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

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

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

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

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

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

19 “(B) The enrollee (or authorized represent-
20 ative).

21 “(C) The health care professional that pro-
22 vides the items or services involved in the de-
23 nial.

1 “(D) The institution at which the items or
2 services (or treatment) involved in the denial
3 are provided.

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

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

10 “(8) DEFINITIONS.—For purposes of this sub-
11 section:

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

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

23 “ENFORCEMENT

24 “SEC. 2799.

25 “(a) IN GENERAL.—Subject to subsection (b), with
26 respect to specific individual health insurance coverage the

1 primary State for such coverage has sole jurisdiction to
2 enforce the primary State’s covered laws in the primary
3 State and any secondary State.

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

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

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

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

22 (c) GAO ONGOING STUDY AND REPORTS.—

23 (1) STUDY.—The Comptroller General of the
24 United States shall conduct an ongoing study con-

1 cerning the effect of the amendment made by sub-
2 section (a) on—

3 (A) the number of uninsured and under-in-
4 sured;

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

8 (C) the availability and cost of health in-
9 surance policies generally;

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

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

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

21 **SEC. 302. SEVERABILITY.**

22 If any provision of the Act or the application of such
23 provision to any person or circumstance is held to be un-
24 constitutional, the remainder of this Act and the applica-

1 tion of the provisions of such to any other person or cir-
2 cumstance shall not be affected.

3 **TITLE IV—EXPANSION OF**
4 **HEALTH SAVINGS ACCOUNTS**
5 **Subtitle A—Promoting Health for**
6 **Future Generations**

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

8 This subtitle may be cited as the “Promoting Health
9 for Future Generations Act of 2008”.

10 **SEC. 402. INCREASE IN HSA CONTRIBUTION LIMITATION.**

11 (a) **IN GENERAL.**—Subsection (b) of section 223 of
12 the Internal Revenue Code of 1986 (relating to monthly
13 limitation) is amended—

14 (1) by striking “\$2,250” in paragraph (2)(A)
15 and inserting “the amount in effect under subsection
16 (c)(2)(A)(ii)(I)”, and

17 (2) by striking “\$4,500” in paragraph (2)(B)
18 and inserting “the amount in effect under subsection
19 (c)(2)(A)(ii)(II)”.

20 (b) **CONFORMING AMENDMENT.**—Paragraph (1) of
21 section 223(g) of such Code is amended by striking “sub-
22 sections (b)(2)” and inserting “subsection”.

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

1 **SEC. 403. MEDICARE AND VA HEALTHCARE ENROLLEES EL-**
2 **IGIBLE TO CONTRIBUTE TO HSA.**

3 (a) IN GENERAL.—(1) Subsection (b) of section 223
4 of the Internal Revenue Code of 1986 is amended by strik-
5 ing paragraph (7).

6 (2) Subsection (c) of section 223 of such Code (relat-
7 ing to definitions and special rules) is amended by adding
8 at the end to following new paragraph:

9 “(6) SPECIAL RULE FOR INDIVIDUALS ENTI-
10 TLED TO BENEFITS UNDER MEDICARE OR EN-
11 ROLLED FOR HEALTH BENEFITS FROM VA.—In the
12 case of an individual—

13 “(A)(i) who is entitled to benefits under
14 title XVIII of the Social Security Act, and

15 “(ii) with respect to whom a health savings
16 account is established in a month before the
17 first month such individual is entitled to such
18 benefits, or

19 “(B)(i) who is enrolled in the patient en-
20 rollment system established by the Secretary of
21 Veterans Affairs pursuant to section 1705 of
22 title 38, United States Code, and

23 “(ii) with respect to whom a health savings
24 account is established in a month before the
25 first month such individual is enrolled in such
26 system,

1 such individual shall be deemed to be an eligible in-
2 dividual.”.

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

6 **SEC. 404. EXPANDING ADDITIONAL CONTRIBUTIONS LIM-**
7 **TATION.**

8 (a) IN GENERAL.—

9 (1) AGE LIMITATION.—Subparagraph (A) of
10 section 223(b)(3) of the Internal Revenue Code of
11 1986 (relating to additional contributions for indi-
12 viduals 55 or older) is amended by striking “age 55”
13 and inserting “age 50”.

14 (2) CONTRIBUTION LIMITATION.—The table
15 contained in section 223(b)(3) of such Code is
16 amended by striking “\$1,000” and inserting
17 “\$2,000”.

18 (3) CONFORMING AMENDMENT.—Paragraph (3)
19 of section 223(b) of such Code is amended in the
20 heading by striking “55” and inserting “50”.

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

1 **SEC. 405. ELIGIBILITY TO CONTRIBUTE TO HSA.**

2 (a) INDIVIDUALS ELIGIBLE FOR REIMBURSEMENT
3 UNDER SPOUSE'S FLEXIBLE SPENDING ARRANGE-
4 MENT.—Section 223(c)(1) of the Internal Revenue Code
5 of 1986 (defining eligible individual) is amended by adding
6 at the end the following new subparagraph:

7 “(C) SPECIAL RULE FOR CERTAIN FLEXI-
8 BLE SPENDING ARRANGEMENTS.—For purposes
9 of subparagraph (A)(ii), an individual shall not
10 be treated as covered under a health plan de-
11 scribed in such subparagraph merely because
12 the individual is covered under a flexible spend-
13 ing arrangement (within the meaning of section
14 106(c)(2)) which is maintained by an employer
15 of the spouse of the individual, but only if—

16 “(i) the employer is not also the em-
17 ployer of the individual, and

18 “(ii) the individual certifies to the em-
19 ployer and to the Secretary (in such form
20 and manner as the Secretary may pre-
21 scribe) that the individual and the individ-
22 ual's spouse will not accept reimbursement
23 under the arrangement for any expenses
24 for medical care provided to the indi-
25 vidual.”.

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

4 **SEC. 406. DEDUCTION OF PREMIUMS FOR HIGH DEDUCT-**
5 **IBLE HEALTH PLANS.**

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 for individuals) is amended
9 by redesignating section 224 as section 225 and by insert-
10 ing after section 223 the following new section:

11 **“SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH**
12 **PLANS.**

13 “(a) DEDUCTION ALLOWED.—In the case of an indi-
14 vidual, there shall be allowed as a deduction for the tax-
15 able year the aggregate amount paid by the taxpayer as
16 premiums under a high deductible health plan with respect
17 to months during such year for which such individual is
18 an eligible individual with respect to such health plan.

19 “(b) DEFINITIONS.—For purposes of this section—

20 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
21 individual’ means an individual who—

22 “(A) is described in section 223(c)(1), and

23 “(B) is the taxpayer or the taxpayer’s
24 spouse and dependents.

1 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The
2 term ‘high deductible health plan’ has the meaning
3 given such term by section 223(c)(2).

4 “(c) SPECIAL RULES.—

5 “(1) DEDUCTION LIMITS.—

6 “(A) DEDUCTION ALLOWABLE FOR ONLY 1
7 PLAN.—For purposes of this section, in the
8 case of an individual covered by more than 1
9 high deductible health plan for any month, the
10 individual may only take into account amounts
11 paid for such month for the plan with the low-
12 est premium.

13 “(B) PLANS COVERING INELIGIBLE INDI-
14 VIDUALS.—If 2 or more individuals are covered
15 by a high deductible health plan for any month
16 but only 1 of such individuals is an eligible indi-
17 vidual for such month, only 50 percent of the
18 aggregate amount paid by such eligible indi-
19 vidual as premiums under the plan with respect
20 to such month shall be taken into account for
21 purposes of this section.

22 “(2) GROUP HEALTH PLAN COVERAGE.—

23 “(A) IN GENERAL.—No deduction shall be
24 allowed for an individual under subsection (a)
25 for any amount paid for coverage under a high

1 deductible health plan for a month if that indi-
2 vidual participates in any coverage under a
3 group health plan (within the meaning of sec-
4 tion 5000 without regard to section 5000(d)).
5 For purposes of the preceding sentence, an ar-
6 rangement which constitutes individual health
7 insurance shall not be treated as a group health
8 plan if such arrangement is a high deductible
9 health plan (as defined in section 223(c)(2)), or
10 is a payment by an employer or employee orga-
11 nization with respect to such high deductible
12 health plan, notwithstanding that an employer
13 or employee organization negotiates the cost or
14 benefits of such arrangement.

15 “(B) EXCEPTION FOR PLANS ONLY PRO-
16 VIDING CONTRIBUTIONS TO HEALTH SAVINGS
17 ACCOUNTS.—Subparagraph (A) shall not apply
18 to an individual if the individual’s only coverage
19 under a group health plan for a month consists
20 of contributions by an employer to a health sav-
21 ings account with respect to which the indi-
22 vidual is the account beneficiary.

23 “(C) EXCEPTION FOR CERTAIN PER-
24 MITTED COVERAGE.—Subparagraph (A) shall
25 not apply to an individual if the individual’s

1 only coverage under a group health plan for a
2 month is coverage described in clause (i) or (ii)
3 of section 223(c)(1)(B).

4 “(3) MEDICAL AND HEALTH SAVINGS AC-
5 COUNTS.—Subsection (a) shall not apply with re-
6 spect to any amount which is paid or distributed out
7 of an Archer MSA or a health savings account which
8 is not included in gross income under section 220(f)
9 or 223(f), as the case may be.

10 “(4) COORDINATION WITH DEDUCTION FOR
11 HEALTH INSURANCE OF SELF-EMPLOYED INDIVID-
12 UALS.—Any amount taken into account by the tax-
13 payer in computing the deduction under section
14 162(l) shall not be taken into account under this
15 section.

16 “(5) COORDINATION WITH MEDICAL EXPENSE
17 DEDUCTION.—Any amount taken into account by
18 the taxpayer in computing the deduction under this
19 section shall not be taken into account under section
20 213.”.

21 (b) DEDUCTION ALLOWED WHETHER OR NOT INDI-
22 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
23 of section 62 of such Code is amended by inserting before
24 the last sentence at the end the following new paragraph:

1 “(22) PREMIUMS FOR HIGH DEDUCTIBLE
2 HEALTH PLANS.—The deduction allowed by section
3 224.”.

4 (c) COORDINATION WITH SECTION 35 HEALTH IN-
5 SURANCE COSTS CREDIT.—Section 35(g)(2) of such Code
6 (relating to coordination with other deductions) is amend-
7 ed by striking “or 213” and inserting “, 213, or 224”.

8 (d) CLERICAL AMENDMENT.—The table of sections
9 for part VII of subchapter B of chapter 1 of such Code
10 is amended by redesignating the item relating to section
11 224 as an item relating to section 225 and by inserting
12 before such item the following new item:

“Sec. 224. Premiums for high deductible health plans.”.

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

16 **SEC. 407. MSA PLAN DEDUCTIBLE EXCEPTION FOR PRE-**
17 **VENTIVE CARE.**

18 (a) IN GENERAL.—Paragraph (3) of section 1859(b)
19 of the Social Security Act (42 U.S.C. 1359w–28(b)) is
20 amended by adding at the end the following new subpara-
21 graph:

22 “(C) EXCEPTION FOR ABSENCE OF PRE-
23 VENTIVE CARE DEDUCTIBLE.—A plan shall not
24 fail to be treated as a MSA plan by reason of
25 failing to have a deductible for preventive care

1 (within the meaning of such term as applied for
2 purposes of section 223(c)(2)(C) of the Internal
3 Revenue Code of 1986).”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 this section shall take effect on January 1, 2009.

6 **SEC. 408. PERMITTING INDIVIDUAL CONTRIBUTIONS TO**
7 **MEDICARE ADVANTAGE MSA.**

8 (a) IN GENERAL.—Paragraph (2) of section 138(b)
9 of the Internal Revenue Code of 1986 (defining Medicare
10 Advantage MSA) is amended by striking “or” at the end
11 of subparagraph (A), by inserting “or” at the end of sub-
12 paragraph (B), and by adding at the end the following
13 new subparagraph:

14 “(C) any contributions by or for the ben-
15 efit of the account holder (other than a con-
16 tribution described in subparagraph (A)) for
17 the taxable year, the sum of which do not ex-
18 ceed the difference of—

19 “(i) the amount of the annual deduct-
20 ible (described in section 1859(b)(3)(B) of
21 the Social Security Act) for the MSA plan
22 in which the individual is enrolled, over

23 “(ii) the amount of contributions de-
24 scribed in subparagraph (A) for the tax-
25 able year.”.

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

4 **SEC. 409. ALLOWING MSA AND HSA ROLLOVER TO ADULT**
5 **CHILD OF ACCOUNT HOLDER.**

6 (a) MSAs.—(1) Subparagraph (A) of section
7 220(f)(8) of the Internal Revenue Code of 1986 (relating
8 to treatment after death of account holder) is amended—

9 (A) by inserting “or adult child” after “sur-
10 viving spouse”,

11 (B) by inserting “or adult child, as the case
12 may be,” after “the spouse”, and

13 (C) by inserting “OR ADULT CHILD” after
14 “SPOUSE” in the heading thereof.

15 (2) Paragraph (8) of section 220(f) of such Code is
16 amended by adding at the end the following new subpara-
17 graph:

18 “(C) ADULT CHILD.—For purposes of this
19 paragraph, the term ‘adult child’ means an in-
20 dividual—

21 “(i) who is a child of the deceased in-
22 dividual, and

23 “(ii) with respect to whom a deduc-
24 tion under section 151 would not be allow-
25 able to another taxpayer for a taxable year

1 beginning in the calendar year in which
2 such individual's taxable year begins.”.

3 (b) HSAs.—(1) Subparagraph (A) of section
4 223(f)(8) of such Code (relating to treatment after death
5 of account beneficiary) is amended—

6 (A) by inserting “or adult child” after “sur-
7 viving spouse”,

8 (B) by inserting “or adult child, as the case
9 may be,” after “the spouse”, and

10 (C) by inserting “OR ADULT CHILD” after
11 “SPOUSE” in the heading thereof.

12 (2) Paragraph (8) of section 223(f) of such Code is
13 amended by adding at the end the following new subpara-
14 graph:

15 “(C) ADULT CHILD.—For purposes of this
16 paragraph, the term ‘adult child’ has the mean-
17 ing given to such term by section
18 220(f)(8)(C).”.

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

1 **SEC. 410. PERMITTING MEDICARE ADVANTAGE MSA FUNDS**
2 **TO BE USED FOR WELLNESS AND FITNESS**
3 **PROGRAMS.**

4 (a) IN GENERAL.—Paragraph (1) of section 138(c)
5 of the Internal Revenue Code of 1986 (relating to special
6 rules for distributions) is amended by striking “and” at
7 the end of subparagraph (A), by striking the period at
8 the end of subparagraph (B) and inserting “, and”, and
9 by adding at the end the following new subparagraph:

10 “(C) qualified medical expenses shall in-
11 clude amounts paid to a gym for enrollment in
12 a wellness or fitness program.”.

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

16 **SEC. 411. HEALTH REIMBURSEMENT ARRANGEMENTS AND**
17 **SPENDING ARRANGEMENTS IN COMBINATION**
18 **WITH HEALTH SAVINGS ACCOUNTS.**

19 (a) IN GENERAL.—Subparagraph (B) of section
20 223(c)(1) of the Internal Revenue Code of 1986 (relating
21 to certain coverage disregarded) is amended by striking
22 “and” at the end of clause (ii), by striking the period at
23 the end of clause (iii) and inserting “, and”, and by insert-
24 ing after clause (iii) the following new clause:

25 “(iv) coverage under a flexible spend-
26 ing arrangement or a health reimburse-

1 ment arrangement, or both, which meets
2 the requirements of paragraph (7).”.

3 (b) COMBINATION HEALTH REIMBURSEMENT, SAV-
4 INGS, AND SPENDING ARRANGEMENTS.—Subsection (c) of
5 section 223 of such Code (relating to definitions and spe-
6 cial rules), as amended by this Act, is amended by adding
7 at the end the following new paragraph:

8 “(7) COMBINED LIMIT FOR CONTRIBUTIONS OR
9 CREDITS TO HEALTH REIMBURSEMENT, ARRANGE-
10 MENTS AND SPENDING ARRANGEMENTS.—

11 “(A) IN GENERAL.—In the case of cov-
12 erage under a flexible spending arrangement or
13 a health reimbursement arrangement, or both,
14 such coverage meets the requirements of this
15 paragraph if, with respect to an individual—

16 “(i) the sum of—

17 “(I) the amount allowable as a
18 deduction under subsection (a),

19 “(II) the salary reduction
20 amount elected by the individual and,
21 if applicable, the employer contribu-
22 tion or credit allocated to the indi-
23 vidual for the taxable year under the
24 flexible spending arrangement (as de-
25 fined in section 106(c)(2)), plus

1 “(III) the amounts that the indi-
2 vidual is permitted, under the terms
3 of the plan, to receive in reimburse-
4 ments for the taxable year under the
5 health reimbursement arrangement,
6 does not exceed

7 “(ii) the sum of the annual deductible
8 and the other annual out-of-pocket ex-
9 penses (other than for premiums) required
10 to be paid under the plan by the eligible
11 individual for covered benefits.

12 “(B) EXCEPTIONS FOR DISREGARDED COV-
13 ERAGE.—For purposes of subparagraph (A)—

14 “(i) CERTAIN FLEXIBLE SPENDING
15 ARRANGEMENTS.—Any flexible spending
16 arrangement salary reduction amounts or
17 employer contributions or credits that are
18 restricted by the employer to use for cov-
19 erage described in paragraph (1)(B) shall
20 not be taken into account under subpara-
21 graph (A)(i)(II).

22 “(ii) CERTAIN HEALTH REIMBURSE-
23 MENT ARRANGEMENTS.—Any reimburse-
24 ments from a health reimbursement ar-
25 rangement for coverage described in para-

1 graph (1)(B) shall not be taken into ac-
2 count under subparagraph (A)(i)(III).

3 “(iii) QUALIFIED HSA DISTRIBUTIONS
4 FROM FSA AND HRA TERMINATIONS.—Any
5 qualified HSA distribution (as defined in
6 section 106(e)) shall not be taken into ac-
7 count under subparagraph (A)(i).

8 “(C) TERMINATION.—Coverage shall not
9 be treated as meeting the requirements of this
10 paragraph for any taxable year beginning after
11 December 31, 2012.”.

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

15 **SEC. 412. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**
16 **INCURRED BEFORE ESTABLISHMENT OF AC-**
17 **COUNT.**

18 (a) IN GENERAL.—Subsection (d) of section 223 of
19 the Internal Revenue Code of 1986 is amended by redesi-
20 gnating paragraph (4) as paragraph (5) and by inserting
21 after paragraph (3) the following new paragraph:

22 “(4) CERTAIN MEDICAL EXPENSES INCURRED
23 BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS
24 QUALIFIED.—

1 “(A) IN GENERAL.—For purposes of para-
2 graph (2), an expense shall not fail to be treat-
3 ed as a qualified medical expense solely because
4 such expense was incurred before the establish-
5 ment of the health savings account if such ex-
6 pense was incurred during the 60-day period
7 beginning on the date on which the high de-
8 ductible health plan is first effective.

9 “(B) SPECIAL RULES.—For purposes of
10 subparagraph (A)—

11 “(i) an individual shall be treated as
12 an eligible individual for any portion of a
13 month for which the individual is described
14 in subsection (c)(1), determined without
15 regard to whether the individual is covered
16 under a high deductible health plan on the
17 1st day of such month, and

18 “(ii) the effective date of the health
19 savings account is deemed to be the date
20 on which the high deductible health plan is
21 first effective after the date of the enact-
22 ment of this paragraph.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply with respect to insurance pur-

1 chased after December 31, 2008, in taxable years begin-
 2 ning after such date.

3 **SEC. 413. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**
 4 **TRIBUTIONS TO THE SAME HSA ACCOUNT.**

5 (a) IN GENERAL.—Paragraph (3) of section 223(b)
 6 of the Internal Revenue Code of 1986 is amended by add-
 7 ing at the end the following new subparagraph:

8 “(C) SPECIAL RULE WHERE BOTH
 9 SPOUSES ARE ELIGIBLE INDIVIDUALS WITH 1
 10 ACCOUNT.—If—

11 “(i) an individual and the individual’s
 12 spouse have both attained age 55 before
 13 the close of the taxable year, and

14 “(ii) the spouse is not an account ben-
 15 eficiary of a health savings account as of
 16 the close of such year,

17 the additional contribution amount shall be 200
 18 percent of the amount otherwise determined
 19 under subparagraph (B).”.

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

23 **SEC. 414. FSA AND HRA TERMINATION TO FUND HSAS.**

24 (a) GRACE PERIOD NOT REQUIRED.—Section
 25 106(e)(2) of the Internal Revenue Code of 1986 is amend-

1 ed by adding at the end the following new sentence: “A
2 distribution shall not fail to be treated as a qualified HSA
3 distribution merely because the balance in such arrange-
4 ment is determined without regard to the requirement that
5 unused amounts remaining at the end of a plan year must
6 be forfeited in the absence of a grace period.”.

7 (b) DEPOSIT IN LIMITED FSA OR HRA OF FUNDS
8 IN EXCESS FSA OR HRA TERMINATION DISTRIBU-
9 TION.—Paragraph (1) of section 106(e) of such Code is
10 amended by inserting before the period at the end thereof
11 the following: “and the deposit of funds in excess of a
12 qualified HSA distribution amount into a health flexible
13 spending account or health reimbursement arrangement
14 which is compatible with a health savings account and
15 which, on the date of such distribution, is a part of the
16 employer’s plan”.

17 (c) DISCLAIMER OF DISQUALIFYING COVERAGE.—
18 Subparagraph (B) of section 223(c)(1) of such Code, as
19 amended by this Act, is amended by striking “and” at the
20 end of clause (iii), by striking the period at the end of
21 clause (iv) and inserting “, and”, and by inserting after
22 clause (iv) the following new clause:

23 “(v) any coverage (whether actual or
24 prospective) otherwise described in sub-
25 paragraph (A)(ii) which is disclaimed at

1 the time of the creation or organization of
2 the health savings account.”.

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

6 **Subtitle B—Increased Access to**
7 **Health Insurance Through HSAs**

8 **SEC. 421. SHORT TITLE.**

9 This subtitle may be cited as the “Increased Access
10 to Health Insurance Act of 2008”.

11 **SEC. 422. PURCHASE OF HEALTH INSURANCE FROM**
12 **HEALTH SAVINGS ACCOUNTS.**

13 (a) IN GENERAL.—Paragraph (2) of section 223(d)
14 of the Internal Revenue Code of 1986 (defining qualified
15 medical expenses) is amended to read as follows:

16 “(2) QUALIFIED MEDICAL EXPENSES.—The
17 term ‘qualified medical expenses’ means, with re-
18 spect to an account beneficiary, amounts paid by
19 such beneficiary for medical care (as defined in sec-
20 tion 213(d)) for such individual, the spouse of such
21 individual, and any dependent (as defined in section
22 152, determined without regard to subsections
23 (b)(1), (b)(2), and (d)(1)(B) thereof) of such indi-
24 vidual, but only to the extent such amounts are not
25 compensated for by insurance or otherwise.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply with respect to insurance pur-
3 chased after the date of the enactment of this Act in tax-
4 able years beginning after such date.

5 **TITLE V—HEALTH CARE TORT**
6 **REFORM**

7 **SEC. 501. FINDINGS AND PURPOSE.**

8 (a) FINDINGS.—

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

20 (2) EFFECT ON INTERSTATE COMMERCE.—
21 Congress finds that the health care and insurance
22 industries are industries affecting interstate com-
23 merce and the health care liability litigation systems
24 existing throughout the United States are activities
25 that affect interstate commerce by contributing to

1 the high costs of health care and premiums for
2 health care liability insurance purchased by health
3 care system providers.

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

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

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

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

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

22 (1) improve the availability of health care serv-
23 ices in cases in which health care liability actions
24 have been shown to be a factor in the decreased
25 availability of services;

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

5 (3) ensure that persons with meritorious health
6 care injury claims receive fair and adequate com-
7 pensation, including reasonable noneconomic dam-
8 ages;

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

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

17 **SEC. 502. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

18 The time for the commencement of a health care law-
19 suit shall be 3 years after the date of manifestation of
20 injury or 1 year after the claimant discovers, or through
21 the use of reasonable diligence should have discovered, the
22 injury, whichever occurs first. In no event shall the time
23 for commencement of a health care lawsuit exceed 3 years
24 after the date of manifestation of injury unless tolled for
25 any of the following—

- 1 (1) upon proof of fraud;
- 2 (2) intentional concealment; or
- 3 (3) the presence of a foreign body, which has no
- 4 therapeutic or diagnostic purpose or effect, in the
- 5 person of the injured person.

6 Actions by a minor shall be commenced within 3 years
7 from the date of the alleged manifestation of injury except
8 that actions by a minor under the full age of 6 years shall
9 be commenced within 3 years of manifestation of injury
10 or prior to the minor's 8th birthday, whichever provides
11 a longer period. Such time limitation shall be tolled for
12 minors for any period during which a parent or guardian
13 and a health care provider or health care organization
14 have committed fraud or collusion in the failure to bring
15 an action on behalf of the injured minor.

16 **SEC. 503. COMPENSATING PATIENT INJURY.**

17 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL
18 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any
19 health care lawsuit, nothing in this title shall limit a claim-
20 ant's recovery of the full amount of the available economic
21 damages, notwithstanding the limitation in subsection (b).

22 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any
23 health care lawsuit, the amount of noneconomic damages,
24 if available, may be as much as \$250,000, regardless of
25 the number of parties against whom the action is brought

1 or the number of separate claims or actions brought with
2 respect to the same injury.

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

17 (d) FAIR SHARE RULE.—In any health care lawsuit,
18 each party shall be liable for that party's several share
19 of any damages only and not for the share of any other
20 person. Each party shall be liable only for the amount of
21 damages allocated to such party in direct proportion to
22 such party's percentage of responsibility. Whenever a
23 judgment of liability is rendered as to any party, a sepa-
24 rate judgment shall be rendered against each such party
25 for the amount allocated to such party. For purposes of

1 this section, the trier of fact shall determine the propor-
2 tion of responsibility of each party for the claimant's
3 harm.

4 **SEC. 504. MAXIMIZING PATIENT RECOVERY.**

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

20 (1) 40 percent of the first \$50,000 recovered by
21 the claimant(s).

22 (2) 33 $\frac{1}{3}$ percent of the next \$50,000 recovered
23 by the claimant(s).

24 (3) 25 percent of the next \$500,000 recovered
25 by the claimant(s).

1 (4) 15 percent of any amount by which the re-
2 covery by the claimant(s) is in excess of \$600,000.

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

12 **SEC. 505. ADDITIONAL HEALTH TORT REFORM BENEFITS.**

13 In any health care lawsuit involving injury or wrong-
14 ful death, any party may introduce evidence of collateral
15 source benefits. If a party elects to introduce such evi-
16 dence, any opposing party may introduce evidence of any
17 amount paid or contributed or reasonably likely to be paid
18 or contributed in the future by or on behalf of the oppos-
19 ing party to secure the right to such collateral source bene-
20 fits. No provider of collateral source benefits shall recover
21 any amount against the claimant or receive any lien or
22 credit against the claimant's recovery or be equitably or
23 legally subrogated to the right of the claimant in a health
24 care lawsuit involving injury or wrongful death. This sec-
25 tion shall apply to any health care lawsuit that is settled

1 as well as a health care lawsuit that is resolved by a fact
2 finder. This section shall not apply to section 1862(b) (42
3 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.
4 1396a(a)(25)) of the Social Security Act.

5 **SEC. 506. PUNITIVE DAMAGES.**

6 (a) IN GENERAL.—Punitive damages may, if other-
7 wise permitted by applicable State or Federal law, be
8 awarded against any person in a health care lawsuit only
9 if it is proven by clear and convincing evidence that such
10 person acted with malicious intent to injure the claimant,
11 or that such person deliberately failed to avoid unneces-
12 sary injury that such person knew the claimant was sub-
13 stantially certain to suffer. In any health care lawsuit
14 where no judgment for compensatory damages is rendered
15 against such person, no punitive damages may be awarded
16 with respect to the claim in such lawsuit. No demand for
17 punitive damages shall be included in a health care lawsuit
18 as initially filed. A court may allow a claimant to file an
19 amended pleading for punitive damages only upon a mo-
20 tion by the claimant and after a finding by the court, upon
21 review of supporting and opposing affidavits or after a
22 hearing, after weighing the evidence, that the claimant has
23 established by a substantial probability that the claimant
24 will prevail on the claim for punitive damages. At the re-

1 quest of any party in a health care lawsuit, the trier of
2 fact shall consider in a separate proceeding—

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

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

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

12 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
13 AGES.—

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

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

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

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

24 (D) the number of products sold or med-
25 ical procedures rendered for compensation, as

1 the case may be, by such party, of the kind
2 causing the harm complained of by the claim-
3 ant;

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

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

10 (2) MAXIMUM AWARD.—The amount of punitive
11 damages, if awarded, in a health care lawsuit may
12 be as much as \$250,000 or as much as two times
13 the amount of economic damages awarded, which-
14 ever is greater. The jury shall not be informed of
15 this limitation.

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

18 (1) IN GENERAL.—

19 (A) No punitive damages may be awarded
20 against the manufacturer or distributor of a
21 medical product, or a supplier of any compo-
22 nent or raw material of such medical product,
23 based on a claim that such product caused the
24 claimant's harm where—

1 (i)(I) such medical product was sub-
2 ject to premarket approval, clearance, or li-
3 censure by the Food and Drug Administra-
4 tion with respect to the safety of the for-
5 mulation or performance of the aspect of
6 such medical product which caused the
7 claimant's harm or the adequacy of the
8 packaging or labeling of such medical
9 product; and

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

12 (ii) such medical product is generally
13 recognized among qualified experts as safe
14 and effective pursuant to conditions estab-
15 lished by the Food and Drug Administra-
16 tion and applicable Food and Drug Admin-
17 istration regulations, including without
18 limitation those related to packaging and
19 labeling, unless the Food and Drug Admin-
20 istration has determined that such medical
21 product was not manufactured or distrib-
22 uted in substantial compliance with appli-
23 cable Food and Drug Administration stat-
24 utes and regulations.

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

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

21 (3) PACKAGING.—In a health care lawsuit for
22 harm which is alleged to relate to the adequacy of
23 the packaging or labeling of a drug which is required
24 to have tamper-resistant packaging under regula-
25 tions of the Secretary of Health and Human Serv-

1 ices (including labeling regulations related to such
2 packaging), the manufacturer or product seller of
3 the drug shall not be held liable for punitive dam-
4 ages unless such packaging or labeling is found by
5 the trier of fact by clear and convincing evidence to
6 be substantially out of compliance with such regula-
7 tions.

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

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

20 (B) a person made an illegal payment to
21 an official of the Food and Drug Administra-
22 tion for the purpose of either securing or main-
23 taining approval, clearance, or licensure of such
24 medical product.

1 **SEC. 507. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
2 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
3 **SUITS.**

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

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

18 **SEC. 508. DEFINITIONS.**

19 In this title:

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

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

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

17 (A) any State or Federal health, sickness,
18 income-disability, accident, or workers’ com-
19 pensation law;

20 (B) any health, sickness, income-disability,
21 or accident insurance that provides health bene-
22 fits or income-disability coverage;

23 (C) any contract or agreement of any
24 group, organization, partnership, or corporation
25 to provide, pay for, or reimburse the cost of

1 medical, hospital, dental, or income-disability
2 benefits; and

3 (D) any other publicly or privately funded
4 program.

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

24 (5) CONTINGENT FEE.—The term “contingent
25 fee” includes all compensation to any person or per-

1 sons which is payable only if a recovery is effected
2 on behalf of one or more claimants.

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

12 (7) HEALTH CARE LAWSUIT.—The term
13 “health care lawsuit” means any health care liability
14 claim concerning the provision of health care goods
15 or services or any medical product affecting inter-
16 state commerce, or any health care liability action
17 concerning the provision of health care goods or
18 services or any medical product affecting interstate
19 commerce, brought in a State or Federal court or
20 pursuant to an alternative dispute resolution system,
21 against a health care provider, a health care organi-
22 zation, or the manufacturer, distributor, supplier,
23 marketer, promoter, or seller of a medical product,
24 regardless of the theory of liability on which the
25 claim is based, or the number of claimants, plain-

1 tiffs, defendants, or other parties, or the number of
2 claims or causes of action, in which the claimant al-
3 leges a health care liability claim. Such term does
4 not include a claim or action which is based on
5 criminal liability; which seeks civil fines or penalties
6 paid to Federal, State, or local government; or which
7 is grounded in antitrust.

8 (8) HEALTH CARE LIABILITY ACTION.—The
9 term “health care liability action” means a civil ac-
10 tion brought in a State or Federal court or pursuant
11 to an alternative dispute resolution system, against
12 a health care provider, a health care organization, or
13 the manufacturer, distributor, supplier, marketer,
14 promoter, or seller of a medical product, regardless
15 of the theory of liability on which the claim is based,
16 or the number of plaintiffs, defendants, or other par-
17 ties, or the number of causes of action, in which the
18 claimant alleges a health care liability claim.

19 (9) HEALTH CARE LIABILITY CLAIM.—The
20 term “health care liability claim” means a demand
21 by any person, whether or not pursuant to ADR,
22 against a health care provider, health care organiza-
23 tion, or the manufacturer, distributor, supplier, mar-
24 keter, promoter, or seller of a medical product, in-
25 cluding, but not limited to, third-party claims, cross-

1 claims, counter-claims, or contribution claims, which
2 are based upon the provision of, use of, or payment
3 for (or the failure to provide, use, or pay for) health
4 care services or medical products, regardless of the
5 theory of liability on which the claim is based, or the
6 number of plaintiffs, defendants, or other parties, or
7 the number of causes of action.

8 (10) HEALTH CARE ORGANIZATION.—The term
9 “health care organization” means any person or en-
10 tity which is obligated to provide or pay for health
11 benefits under any health plan, including any person
12 or entity acting under a contract or arrangement
13 with a health care organization to provide or admin-
14 ister any health benefit.

15 (11) HEALTH CARE PROVIDER.—The term
16 “health care provider” means any person or entity
17 required by State or Federal laws or regulations to
18 be licensed, registered, or certified to provide health
19 care services, and being either so licensed, reg-
20 istered, or certified, or exempted from such require-
21 ment by other statute or regulation.

22 (12) HEALTH CARE GOODS OR SERVICES.—The
23 term “health care goods or services” means any
24 goods or services provided by a health care organiza-
25 tion, provider, or by any individual working under

1 the supervision of a health care provider, that relates
2 to the diagnosis, prevention, or treatment of any
3 human disease or impairment, or the assessment or
4 care of the health of human beings.

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

10 (14) MEDICAL PRODUCT.—The term “medical
11 product” means a drug, device, or biological product
12 intended for humans, and the terms “drug”, “de-
13 vice”, and “biological product” have the meanings
14 given such terms in sections 201(g)(1) and 201(h)
15 of the Federal Food, Drug and Cosmetic Act (21
16 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
17 Public Health Service Act (42 U.S.C. 262(a)), re-
18 spectively, including any component or raw material
19 used therein, but excluding health care services.

20 (15) NONECONOMIC DAMAGES.—The term
21 “noneconomic damages” means damages for phys-
22 ical and emotional pain, suffering, inconvenience,
23 physical impairment, mental anguish, disfigurement,
24 loss of enjoyment of life, loss of society and compan-
25 ionship, loss of consortium (other than loss of do-

1 mestic service), hedonic damages, injury to reputa-
2 tion, and all other nonpecuniary losses of any kind
3 or nature.

4 (16) PUNITIVE DAMAGES.—The term “punitive
5 damages” means damages awarded, for the purpose
6 of punishment or deterrence, and not solely for com-
7 pensatory purposes, against a health care provider,
8 health care organization, or a manufacturer, dis-
9 tributor, or supplier of a medical product. Punitive
10 damages are neither economic nor noneconomic
11 damages.

12 (17) RECOVERY.—The term “recovery” means
13 the net sum recovered after deducting any disburse-
14 ments or costs incurred in connection with prosecu-
15 tion or settlement of the claim, including all costs
16 paid or advanced by any person. Costs of health care
17 incurred by the plaintiff and the attorneys’ office
18 overhead costs or charges for legal services are not
19 deductible disbursements or costs for such purpose.

20 (18) STATE.—The term “State” means each of
21 the several States, the District of Columbia, the
22 Commonwealth of Puerto Rico, the Virgin Islands,
23 Guam, American Samoa, the Northern Mariana Is-
24 lands, the Trust Territory of the Pacific Islands, and

1 any other territory or possession of the United
2 States, or any political subdivision thereof.

3 **SEC. 509. EFFECT ON OTHER LAWS.**

4 (a) VACCINE INJURY.—

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

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

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

14 (2) If there is an aspect of a civil action
15 brought for a vaccine-related injury or death to
16 which a Federal rule of law under title XXI of the
17 Public Health Service Act does not apply, then this
18 title or otherwise applicable law (as determined
19 under this title) will apply to such aspect of such ac-
20 tion.

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

1 **SEC. 510. STATE FLEXIBILITY AND PROTECTION OF**
2 **STATES' RIGHTS.**

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

11 (1) provides for a greater amount of damages
12 or contingent fees, a longer period in which a health
13 care lawsuit may be commenced, or a reduced appli-
14 cability or scope of periodic payment of future dam-
15 ages, than provided in this title; or

16 (2) prohibits the introduction of evidence re-
17 garding collateral source benefits, or mandates or
18 permits subrogation or a lien on collateral source
19 benefits.

20 (b) **PROTECTION OF STATES' RIGHTS AND OTHER**
21 **LAWS.**—(1) Any issue that is not governed by any provi-
22 sion of law established by or under this title (including
23 State standards of negligence) shall be governed by other-
24 wise applicable State or Federal law.

25 (2) This title shall not preempt or supersede any
26 State or Federal law that imposes greater procedural or

1 substantive protections for health care providers and
2 health care organizations from liability, loss, or damages
3 than those provided by this title or create a cause of ac-
4 tion.

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

7 (1) any State law (whether effective before, on,
8 or after the date of the enactment of this Act) that
9 specifies a particular monetary amount of compen-
10 satory or punitive damages (or the total amount of
11 damages) that may be awarded in a health care law-
12 suit, regardless of whether such monetary amount is
13 greater or lesser than is provided for under this title,
14 notwithstanding section 4(a); or

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

18 **SEC. 511. APPLICABILITY; EFFECTIVE DATE.**

19 This title shall apply to any health care lawsuit
20 brought in a Federal or State court, or subject to an alter-
21 native dispute resolution system, that is initiated on or
22 after the date of the enactment of this Act, except that
23 any health care lawsuit arising from an injury occurring
24 prior to the date of the enactment of this Act shall be

1 governed by the applicable statute of limitations provisions
2 in effect at the time the injury occurred.

3 **SEC. 512. SENSE OF CONGRESS.**

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

8 **TITLE VI—HEALTH**
9 **INFORMATION TECHNOLOGY**
10 **Subtitle A—Assisting the Develop-**
11 **ment of Health Information**
12 **Technology**

13 **SEC. 601. PURPOSE.**

14 It is the purpose of this subtitle to promote the utili-
15 zation of health record banking by improving the coordina-
16 tion of health information through an infrastructure for
17 the secure and authorized exchange and use of healthcare
18 information.

19 **SEC. 602. HEALTH RECORD BANKING.**

20 (a) **ESTABLISHMENT.**—Not later than 1 year after
21 the date of enactment of this Act, the Secretary of Health
22 and Human Services shall promulgate regulations to pro-
23 vide for the certification and auditing of the banking of
24 electronic medical records.

1 (b) GENERAL RIGHTS.—An individual who has a
2 health record contained in a health record bank shall
3 maintain ownership over the health record and shall have
4 the right to review the contents of the record.

5 **SEC. 603. APPLICATION OF FEDERAL AND STATE SECURITY**
6 **AND CONFIDENTIALITY STANDARDS.**

7 (a) IN GENERAL.—Current Federal security and con-
8 fidentiality standards and State security and confiden-
9 tiality laws shall apply to this subtitle until such time as
10 Congress acts to amend such standards.

11 (b) DEFINITIONS.—In this section:

12 (1) CURRENT FEDERAL SECURITY AND CON-
13 FIDENTIALITY STANDARDS.—The term “current
14 Federal security and confidentiality standards”
15 means the Federal privacy standards established
16 pursuant to section 264(c) of the Health Insurance
17 Portability and Accountability Act of 1996 (42
18 U.S.C. 1320d–2 note) and security standards estab-
19 lished under section 1173(d) of the Social Security
20 Act (42 U.S.C. 1320d–2(d)).

21 (2) STATE SECURITY AND CONFIDENTIALITY
22 LAWS.—The term “State security and confidentiality
23 laws” means State laws and regulations relating to
24 the privacy and confidentiality of individually identi-

1 fiable health information or to the security of such
2 information.

3 (3) STATE.—The term “State” has the mean-
4 ing given such term for purposes of title XI of the
5 Social Security Act, as provided under section
6 1101(a) of such Act (42 U.S.C. 1301(a)).

7 **Subtitle B—Promoting the Use of**
8 **Health Information Technology**
9 **to Better Coordinate Health**
10 **Care**

11 **SEC. 611. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**
12 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**
13 **VISION OF HEALTH INFORMATION TECH-**
14 **NOLOGY AND TRAINING SERVICES.**

15 (a) FOR CIVIL PENALTIES.—Section 1128A of the
16 Social Security Act (42 U.S.C. 1320a–7a) is amended—

17 (1) in subsection (b), by adding at the end the
18 following new paragraph:

19 “(4) For purposes of this subsection, inducements to
20 reduce or limit services described in paragraph (1) shall
21 not include the practical or other advantages resulting
22 from health information technology or related installation,
23 maintenance, support, or training services.”; and

24 (2) in subsection (i), by adding at the end the
25 following new paragraph:

1 “(8) The term ‘health information technology’
2 means hardware, software, license, right, intellectual
3 property, equipment, or other information tech-
4 nology (including new versions, upgrades, and
5 connectivity) designed or provided primarily for the
6 electronic creation, maintenance, or exchange of
7 health information to better coordinate care or im-
8 prove health care quality, efficiency, or research.”.

9 (b) FOR CRIMINAL PENALTIES.—Section 1128B of
10 such Act (42 U.S.C. 1320a–7b) is amended—

11 (1) in subsection (b)(3)—

12 (A) in subparagraph (G), by striking
13 “and” at the end;

14 (B) in the subparagraph (H) added by sec-
15 tion 237(d) of the Medicare Prescription Drug,
16 Improvement, and Modernization Act of 2003
17 (Public Law 108–173; 117 Stat. 2213)—

18 (i) by moving such subparagraph 2
19 ems to the left; and

20 (ii) by striking the period at the end
21 and inserting a semicolon;

22 (C) in the subparagraph (H) added by sec-
23 tion 431(a) of such Act (117 Stat. 2287)—

24 (i) by redesignating such subpara-
25 graph as subparagraph (I);

1 (ii) by moving such subparagraph 2
2 ems to the left; and

3 (iii) by striking the period at the end
4 and inserting “; and”; and

5 (D) by adding at the end the following new
6 subparagraph:

7 “(J) any nonmonetary remuneration (in the
8 form of health information technology, as defined in
9 section 1128A(i)(8), or related installation, mainte-
10 nance, support or training services) made to a per-
11 son by a specified entity (as defined in subsection
12 (g)) if—

13 “(i) the provision of such remuneration is
14 without an agreement between the parties or
15 legal condition that—

16 “(I) limits or restricts the use of the
17 health information technology to services
18 provided by the physician to individuals re-
19 ceiving services at the specified entity;

20 “(II) limits or restricts the use of the
21 health information technology in conjunc-
22 tion with other health information tech-
23 nology; or

1 “(III) conditions the provision of such
2 remuneration on the referral of patients or
3 business to the specified entity;

4 “(ii) such remuneration is arranged for in
5 a written agreement that is signed by the par-
6 ties involved (or their representatives) and that
7 specifies the remuneration solicited or received
8 (or offered or paid) and states that the provi-
9 sion of such remuneration is made for the pri-
10 mary purpose of better coordination of care or
11 improvement of health quality, efficiency, or re-
12 search; and

13 “(iii) the specified entity providing the re-
14 muneration (or a representative of such entity)
15 has not taken any action to disable any basic
16 feature of any hardware or software component
17 of such remuneration that would permit inter-
18 operability.”; and

19 (2) by adding at the end the following new sub-
20 section:

21 “(g) SPECIFIED ENTITY DEFINED.—For purposes of
22 subsection (b)(3)(J), the term ‘specified entity’ means an
23 entity that is a hospital, group practice, prescription drug
24 plan sponsor, a Medicare Advantage organization, or any
25 other such entity specified by the Secretary, considering

1 the goals and objectives of this section, as well as the goals
2 to better coordinate the delivery of health care and to pro-
3 mote the adoption and use of health information tech-
4 nology.”.

5 (c) EFFECTIVE DATE AND EFFECT ON STATE
6 LAWS.—

7 (1) EFFECTIVE DATE.—The amendments made
8 by subsections (a) and (b) shall take effect on the
9 date that is 120 days after the date of the enact-
10 ment of this Act.

11 (2) PREEMPTION OF STATE LAWS.—No State
12 (as defined in section 1101(a) of the Social Security
13 Act (42 U.S.C. 1301(a)) for purposes of title XI of
14 such Act) shall have in effect a State law that im-
15 poses a criminal or civil penalty for a transaction de-
16 scribed in section 1128A(b)(4) or section
17 1128B(b)(3)(J) of such Act, as added by subsections
18 (a)(1) and (b), respectively, if the conditions de-
19 scribed in the respective provision, with respect to
20 such transaction, are met.

21 (d) STUDY AND REPORT TO ASSESS EFFECT OF
22 SAFE HARBORS ON HEALTH SYSTEM.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services shall conduct a study to determine
25 the impact of each of the safe harbors described in

1 paragraph (3). In particular, the study shall examine
2 the following:

3 (A) The effectiveness of each safe harbor
4 in increasing the adoption of health information
5 technology.

6 (B) The types of health information tech-
7 nology provided under each safe harbor.

8 (C) The extent to which the financial or
9 other business relationships between providers
10 under each safe harbor have changed as a re-
11 sult of the safe harbor in a way that adversely
12 affects or benefits the health care system or
13 choices available to consumers.

14 (D) The impact of the adoption of health
15 information technology on health care quality,
16 cost, and access under each safe harbor.

17 (2) REPORT.—Not later than 3 years after the
18 effective date described in subsection (c)(1), the Sec-
19 retary of Health and Human Services shall submit
20 to Congress a report on the study under paragraph
21 (1).

22 (3) SAFE HARBORS DESCRIBED.—For purposes
23 of paragraphs (1) and (2), the safe harbors de-
24 scribed in this paragraph are—

1 (A) the safe harbor under section
 2 1128A(b)(4) of such Act (42 U.S.C. 1320a-
 3 7a(b)(4)), as added by subsection (a)(1); and

4 (B) the safe harbor under section
 5 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-
 6 7b(b)(3)(J)), as added by subsection (b).

7 **SEC. 612. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**
 8 **CIAN REFERRALS (UNDER STARK) FOR PRO-**
 9 **VISION OF HEALTH INFORMATION TECH-**
 10 **NOLOGY AND TRAINING SERVICES TO**
 11 **HEALTH CARE PROFESSIONALS.**

12 (a) IN GENERAL.—Section 1877(b) of the Social Se-
 13 curity Act (42 U.S.C. 1395nn(b)) is amended by adding
 14 at the end the following new paragraph:

15 “(6) INFORMATION TECHNOLOGY AND TRAIN-
 16 ING SERVICES.—

17 “(A) IN GENERAL.—Any nonmonetary re-
 18 munerated (in the form of health information
 19 technology or related installation, maintenance,
 20 support or training services) made by a speci-
 21 fied entity to a physician if—

22 “(i) the provision of such remunera-
 23 tion is without an agreement between the
 24 parties or legal condition that—

1 “(I) limits or restricts the use of
2 the health information technology to
3 services provided by the physician to
4 individuals receiving services at the
5 specified entity;

6 “(II) limits or restricts the use of
7 the health information technology in
8 conjunction with other health informa-
9 tion technology; or

10 “(III) conditions the provision of
11 such remuneration on the referral of
12 patients or business to the specified
13 entity;

14 “(ii) such remuneration is arranged
15 for in a written agreement that is signed
16 by the parties involved (or their represent-
17 atives) and that specifies the remuneration
18 made and states that the provision of such
19 remuneration is made for the primary pur-
20 pose of better coordination of care or im-
21 provement of health quality, efficiency, or
22 research; and

23 “(iii) the specified entity (or a rep-
24 resentative of such entity) has not taken
25 any action to disable any basic feature of

1 any hardware or software component of
2 such remuneration that would permit
3 interoperability.

4 “(B) HEALTH INFORMATION TECHNOLOGY
5 DEFINED.—For purposes of this paragraph, the
6 term ‘health information technology’ means
7 hardware, software, license, right, intellectual
8 property, equipment, or other information tech-
9 nology (including new versions, upgrades, and
10 connectivity) designed or provided primarily for
11 the electronic creation, maintenance, or ex-
12 change of health information to better coordi-
13 nate care or improve health care quality, effi-
14 ciency, or research.

15 “(C) SPECIFIED ENTITY DEFINED.—For
16 purposes of this paragraph, the term ‘specified
17 entity’ means an entity that is a hospital, group
18 practice, prescription drug plan sponsor, a
19 Medicare Advantage organization, or any other
20 such entity specified by the Secretary, consid-
21 ering the goals and objectives of this section, as
22 well as the goals to better coordinate the deliv-
23 ery of health care and to promote the adoption
24 and use of health information technology.”.

25 (b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

1 (1) EFFECTIVE DATE.—The amendment made
2 by subsection (a) shall take effect on the date that
3 is 120 days after the date of the enactment of this
4 Act.

5 (2) PREEMPTION OF STATE LAWS.—No State
6 (as defined in section 1101(a) of the Social Security
7 Act (42 U.S.C. 1301(a)) for purposes of title XI of
8 such Act) shall have in effect a State law that im-
9 poses a criminal or civil penalty for a transaction de-
10 scribed in section 1877(b)(6) of such Act, as added
11 by subsection (a), if the conditions described in such
12 section, with respect to such transaction, are met.

13 (c) STUDY AND REPORT TO ASSESS EFFECT OF EX-
14 CEPTION ON HEALTH SYSTEM.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services shall conduct a study to determine
17 the impact of the exception under section 1877(b)(6)
18 of such Act (42 U.S.C. 1395nn(b)(6)), as added by
19 subsection (a). In particular, the study shall examine
20 the following:

21 (A) The effectiveness of the exception in
22 increasing the adoption of health information
23 technology.

24 (B) The types of health information tech-
25 nology provided under the exception.

1 (C) The extent to which the financial or
2 other business relationships between providers
3 under the exception have changed as a result of
4 the exception in a way that adversely affects or
5 benefits the health care system or choices avail-
6 able to consumers.

7 (D) The impact of the adoption of health
8 information technology on health care quality,
9 cost, and access under the exception.

10 (2) REPORT.—Not later than 3 years after the
11 effective date described in subsection (b)(1), the Sec-
12 retary of Health and Human Services shall submit
13 to Congress a report on the study under paragraph
14 (1).

15 **SEC. 613. RULES OF CONSTRUCTION REGARDING USE OF**
16 **CONSORTIA.**

17 (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL
18 PENALTIES.—Section 1128B(b)(3) of the Social Security
19 Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding
20 after and below subparagraph (J), as added by section
21 611(b)(1), the following: “For purposes of subparagraph
22 (J), nothing in such subparagraph shall be construed as
23 preventing a specified entity, consistent with the specific
24 requirements of such subparagraph, from forming a con-
25 sortium composed of health care providers, payers, em-

1 ployers, and other interested entities to collectively pur-
2 chase and donate health information technology, or from
3 offering health care providers a choice of health informa-
4 tion technology products in order to take into account the
5 varying needs of such providers receiving such products.”.

6 (b) APPLICATION TO STARK EXCEPTION.—Para-
7 graph (6) of section 1877(b) of the Social Security Act
8 (42 U.S.C. 1395nn(b)), as added by section 612(a), is
9 amended by adding at the end the following new subpara-
10 graph:

11 “(D) RULE OF CONSTRUCTION.—For pur-
12 poses of subparagraph (A), nothing in such
13 subparagraph shall be construed as preventing
14 a specified entity, consistent with the specific
15 requirements of such subparagraph, from—

16 “(i) forming a consortium composed
17 of health care providers, payers, employers,
18 and other interested entities to collectively
19 purchase and donate health information
20 technology; or

21 “(ii) offering health care providers a
22 choice of health information technology
23 products in order to take into account the

1 varying needs of such providers receiving
2 such products.”.

○