

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 saling/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           “(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 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           “(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 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.”.

○