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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Making Health Care More Affordable Act of 2008”.

(b) Table of Contents.—The table of contents of 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.

TITe II—SMALL BUSINESS HEALTH PLANS

Sec. 201. Rules governing association health plans.
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.

TITe III—PURCHASE HEALTH INSURANCE ACROSS STATE LINES

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

TITe 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.

TITe 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.

TITLE I—HEALTH INSURANCE

TAX CREDIT

SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) In general.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. QUALIFIED HEALTH INSURANCE TAX CREDIT.

"(a) In general.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for the taxpayer and the taxpayer’s spouse or dependent."
“(b) LIMITATIONS.—

“(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for the individual referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

“(2) MONTHLY LIMITATION.—

“(A) IN GENERAL.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to $ of the qualified health insurance amount.

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

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

“(ii) $2,500 if such individual is the spouse of the taxpayer, the taxpayer and such spouse are married as of the first day of such month, and the taxpayer files a joint return for the taxable year, or
“(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

“(C) LIMITATION ON DEPENDENTS.—Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (B)(iii).

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

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

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

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

“(B) MEDICARE.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual has not made an election to establish and maintain a Medical Retirement Account under section 252(a)(2) of the Social Security Act and
is entitled to benefits under title XVIII of the Social Security Act.

“(C) CERTAIN OTHER COVERAGE.—Such term shall not include any month during a taxable year with respect to an individual if, at any time during such year, any benefit is provided to such individual under—

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

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

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

“(D) PRISONERS.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

“(E) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).
“(c) Qualified Health Insurance.—For purposes of this section—

“(1) In General.—The term ‘qualified health insurance’ means any health plan (within the meaning of section 223(c)(2)) determined without regard to any annual deductible requirement.

“(2) Annual Wellness Exam.—Such term shall include an annual wellness exam fee not to exceed $150 ($100 in the case of an annual child wellness exam) if such exam is not covered by the insurance.

“(d) Archer MSA and Health Savings Account Contributions.—

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

“(2) Denial of Double Benefit.—No deduction shall be allowed under section 220 or 223 for that portion of the payments otherwise allowable as a deduction under section 220 or 223 for the taxable
year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

“(e) Special Rules.—For purposes of this section—

“(1) Married couples must file joint return.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and the taxpayer’s spouse file a joint return for the taxable year.

“(2) Denial of credit to dependents.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(3) Denial of double benefit.—No credit shall be allowed under subsection (a) if the credit under section 35 is allowed and no credit shall be allowed under 35 if a credit is allowed under this section.

“(4) Coordination with deduction for health insurance costs.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) or 213 for the taxable year, this sec-
tion shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

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

“(6) INFLATION ADJUSTMENT.—

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

“(i) such dollar amount, multiplied by

“(ii) the cost-of-living adjustment determined under subparagraph (B) for the calendar year in which such taxable year begins.

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

“(i) the GDP for the preceding calendar year, exceeds

“(ii) the GDP for calendar year 2007.
“(C) GDP FOR ANY CALENDAR YEAR.—
For purposes of subparagraph (B), the GDP for any calendar year is the average of the chain-weighted price index for the gross domestic product as of the close of the 12-month period ending on March 31 of such calendar year.

“(D) CHAIN-WEIGHTED PRICE INDEX FOR THE GROSS DOMESTIC PRODUCT.—For purposes of subparagraph (C), the term ‘chain-weighted price index for the gross domestic product’ means the last chain-weighted price index for the gross domestic product published by the Department of Commerce.

“(E) ROUNDING.—Any increase determined under subparagraph (A) shall be rounded to the nearest multiple of $50.”.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050V the following new section:
SEC. 6050W. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

“(a) In General.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

“(b) Form and Manner of Returns.—A return is described in this subsection if such return—

“(1) is in such form as the Secretary may prescribe, and

“(2) contains—

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

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

“(C) such other information as the Secretary may reasonably prescribe.
“(c) Creditable Health Insurance.—For purposes of this section, the term ‘creditable health insurance’ means qualified health insurance (as defined in section 36(c)) other than, to the extent provided in regulations prescribed by the Secretary, any insurance covering an individual if no credit is allowable under section 36 with respect to such coverage.

“(d) Statements To Be Furnished to Individuals With Respect to Whom Information Is Required.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

“(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

“(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

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

The written statement required under the preceding sentence shall be furnished on or before January 31 of the
year following the calendar year for which the return under subsection (a) is required to be made.

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

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xv) through (xx) as clauses (xvi) through (xxi), respectively, and by inserting after clause (xi) the following new clause:

“(xv) section 6050W (relating to returns relating to payments for qualified health insurance),”.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking the period at the end of subparagraph (CC) and inserting “, or” and by adding at the end the following new subparagraph:
“(DD) section 6050W(d) (relating to returns relating to payments for qualified health insurance).”.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050V the following new item:

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

(e) CONFORMING AMENDMENTS.—

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

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

“Sec. 36. Qualified health insurance tax credit.

Sec. 37. Overpayments of tax.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.
SEC. 102. ADVANCE PAYMENT OF CREDIT FOR PUR- 
CHASERS OF QUALIFIED HEALTH INSUR-
ANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Rev-


enue Code of 1986 (relating to miscellaneous provisions) 
is amended by adding at the end the following new section:

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

“(a) GENERAL RULE.—In the case of an eligible indi-


vidual, the Secretary shall make payments to the provider 
of such individual’s qualified health insurance equal to 
such individual’s qualified health insurance credit advance 
amount with respect to such provider.

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


vidual—

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

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

“(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGI-
BILITY CERTIFICATE.—For purposes of this section, a 
qualified health insurance credit eligibility certificate is a 
statement furnished by an individual to the Secretary 
which—
“(1) certifies that the individual will be eligible to receive the credit provided by section 36 for the taxable year,
“(2) estimates the amount of such credit for such taxable year, and
“(3) provides such other information as the Secretary may require for purposes of this section.
“(d) Qualified Health Insurance Credit Advance Amount.—For purposes of this section, the term ‘qualified health insurance credit advance amount’ means, with respect to any provider of qualified health insurance, the Secretary’s estimate of the amount of credit allowable under section 36 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.
“(e) Regulations.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.”.

(b) Clerical Amendment.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:
“Sec. 7529. Advance payment of qualified health insurance tax credit.”.

(e) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.
TITLE II—SMALL BUSINESS HEALTH PLANS

SEC. 201. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

“(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, in-
including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986), for substantial purposes other than that of obtaining or providing medical care;

“(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

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

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

“(a) In General.—The applicable authority shall prescribe by regulation a procedure under which, subject
to subsection (b), the applicable authority shall certify as-

sociation health plans which apply for certification as

meeting the requirements of this part.

“(b) Standards.—Under the procedure prescribed

pursuant to subsection (a), in the case of an association

health plan that provides at least one benefit option which

does not consist of health insurance coverage, the applica-

ble authority shall certify such plan as meeting the re-

quirements of this part only if the applicable authority is

satisfied that the applicable requirements of this part are

met (or, upon the date on which the plan is to commence

operations, will be met) with respect to the plan.

“(c) Requirements Applicable to Certified

Plans.—An association health plan with respect to which

certification under this part is in effect shall meet the ap-

licable requirements of this part, effective on the date

of certification (or, if later, on the date on which the plan

is to commence operations).

“(d) Requirements for Continued Certification.

—The applicable authority may provide by regula-

tion for continued certification of association health plans

under this part.

“(e) Class Certification for Fully Insured

Plans.—The applicable authority shall establish a class

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

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

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

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

“(3) a plan whose eligible participating employ-
ers represent one or more trades or businesses, or one or more industries, consisting of any of the fol-
lowing: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public
accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

“(a) Sponsor.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part."
“(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

“(1) Fiscal control.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

“(2) Rules of operation and financial controls.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

“(3) Rules governing relationship to participating employers and to contractors.—

“(A) Board membership.—

“(i) In general.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in
the participating employers and actively
participate in the business.

“(ii) Limitation.—

“(I) General rule.—Except as
provided in subclauses (II) and (III),
no such member is an owner, officer,
director, or employee of, or partner in,
a contract administrator or other
service provider to the plan.

“(II) Limited exception for
providers of services solely on
behalf of the sponsor.—Officers
or employees of a sponsor which is a
service provider (other than a contract
administrator) to the plan may be
members of the board if they con-
stitute not more than 25 percent of
the membership of the board and they
do not provide services to the plan
other than on behalf of the sponsor.

“(III) Treatment of pro-
viders of medical care.—In the
case of a sponsor which is an associa-
tion whose membership consists pri-
marily of providers of medical care,
subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

“(iii) Certain plans excluded.—Clause (I) shall not apply to an association health plan which is in existence on the date of the enactment of the Making Health Care More Affordable Act of 2008.

“(B) Sole authority.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

“(c) Treatment of franchise networks.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

“(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee
were deemed to be a member (of the association and
the sponsor) referred to in section 801(b); and
“(2) the requirements of section 804(a)(1) shall
be deemed met.
The Secretary may by regulation define for purposes of
this subsection the terms ‘franchiser’, ‘franchise network’,
and ‘franchisee’.

“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-
MENTS.
“(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
requirements of this subsection are met with respect to
an association health plan if, under the terms of the
plan—
“(1) each participating employer must be—
“(A) a member of the sponsor,
“(B) the sponsor, or
“(C) an affiliated member of the sponsor
with respect to which the requirements of sub-
section (b) are met,
except that, in the case of a sponsor which is a pro-
fessional association or other individual-based asso-
ciation, if at least one of the officers, directors, or
employees of an employer, or at least one of the in-
dividuals who are partners in an employer and who
actively participates in the business, is a member or
such an affiliated member of the sponsor, participating employers may also include such employer; and

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

“(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

“(B) the beneficiaries of individuals described in subparagraph (A).

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

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

“(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employ-
ees who would otherwise be eligible to participate in
such association health plan.

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

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

“(1) under the terms of the plan, all employers
meeting the preceding requirements of this section
are eligible to qualify as participating employers for
all geographically available coverage options, unless,
in the case of any such employer, participation or
contribution requirements of the type referred to in
section 2711 of the Public Health Service Act are not met;

“(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

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

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

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

“(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

“(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));
“(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

“(C) incorporates the requirements of section 806.

“(2) Contribution rates must be non-discriminatory.—

“(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

“(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

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

“(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same
methodology employed in such State for
regulating premium rates in the small
group market with respect to health insur-
ance coverage offered in connection with
bona fide associations (within the meaning
of section 2791(d)(3) of the Public Health
Service Act),

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

“(3) **Floor for Number of Covered Individuals with Respect to Certain Plans.**—If
any benefit option under the plan does not consist
of health insurance coverage, the plan has as of the
beginning of the plan year not fewer than 1,000 par-
ticipants and beneficiaries.

“(4) **Marketing Requirements.**—

“(A) **In General.**—If a benefit option
which consists of health insurance coverage is
offered under the plan, State-licensed insurance
agents shall be used to distribute to small em-
ployers coverage which does not consist of
health insurance coverage in a manner com-
parable to the manner in which such agents are
used to distribute health insurance coverage.
“(B) State-licensed insurance agents.—For purposes of subparagraph (A), the term ‘State-licensed insurance agents’ means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

“(5) Regulatory requirements.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

“(b) Ability of association health plans to design benefit options.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(e)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under...
section 731(a)(1) with respect to matters governed by sec-
tion 711, 712, or 713, or (2) any law of the State with
which filing and approval of a policy type offered by the
plan was initially obtained to the extent that such law pro-
hibits an exclusion of a specific disease from such cov-
verage.

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

“(a) IN GENERAL.—The requirements of this section
are met with respect to an association health plan if—
“(1) the benefits under the plan consist solely
of health insurance coverage; or
“(2) if the plan provides any additional benefit
options which do not consist of health insurance cov-
verage, the plan—
“(A) establishes and maintains reserves
with respect to such additional benefit options,
in amounts recommended by the qualified actu-
ary, consisting of—
“(i) a reserve sufficient for unearned
contributions;
“(ii) a reserve sufficient for benefit li-
abilities which have been incurred, which
have not been satisfied, and for which risk
of loss has not yet been transferred, and
for expected administrative costs with re-
spect to such benefit liabilities;

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

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

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

“(i) The plan shall secure aggregate
excess/stop loss insurance for the plan with
an attachment point which is not greater
than 125 percent of expected gross annual
claims. The applicable authority may by
regulation provide for upward adjustments
in the amount of such percentage in speci-
fied circumstances in which the plan spe-
cifically provides for and maintains re-
serves in excess of the amounts required under subparagraph (A).

“(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan’s qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in clause (I), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable authority pursuant to clause (I) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may rec-
ommend, taking into account the specific circumstances of the plan.

“(b) Minimum Surplus in Addition to Claims Reserves.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

“(1) $500,000, or

“(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, considering the level of aggregate and specific excess/stop loss insurance provided with respect to such plan and other factors related to solvency risk, such as the plan’s projected levels of participation or claims, the nature of the plan’s liabilities, and the types of assets available to assure that such liabilities are met.

“(c) Additional Requirements.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves, excess/stop loss insurance, and indemnification insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation with respect to any such plan or any class of such plans.
“(d) Adjustments for Excess/Stop Loss Insurance.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

“(e) Alternative Means of Compliance.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.
“(f) Measures To Ensure Continued Payment of Benefits by Certain Plans in Distress.—

“(1) Payments by Certain Plans to Association Health Plan Fund.—

“(A) In General.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan’s assets are distributed pursuant to a termination procedure.

“(B) Penalties for Failure to Make Payments.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment
which was not timely paid shall be payable by
the plan to the Fund.

“(C) CONTINUED DUTY OF THE sec-
retARY.—The Secretary shall not cease to
carry out the provisions of paragraph (2) on ac-
count of the failure of a plan to pay any pay-
ment when due.

“(2) PAYMENTS BY secretARY TO CONTINUE
EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
DEMNIFICATION INSURANCE COVERAGE FOR CER-
TAIN PLANS.—In any case in which the applicable
authority determines that there is, or that there is
reason to believe that there will be: (A) a failure to
take necessary corrective actions under section
809(a) with respect to an association health plan de-
scribed in subsection (a)(2); or (B) a termination of
such a plan under section 809(b) or 810(b)(8) (and,
if the applicable authority is not the Secretary, cer-
tifies such determination to the Secretary), the Sec-
retary shall determine the amounts necessary to
make payments to an insurer (designated by the
Secretary) to maintain in force excess/stop loss in-
surance coverage or indemnification insurance cov-
erage for such plan, if the Secretary determines that
there is a reasonable expectation that, without such
payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

“(3) ASSOCIATION HEALTH PLAN FUND.—

“(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

“(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

“(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—
“(1) **AGGREGATE EXCESS/STOP LOSS INSURANCE.**—The term ‘aggregate excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

“(B) which is guaranteed renewable; and

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

“(2) **SPECIFIC EXCESS/STOP LOSS INSURANCE.**—The term ‘specific excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in
such contract in connection with such covered individual;

“(B) which is guaranteed renewable; and

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

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

“(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

“(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

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

“(i) RESERVES.—For purposes of this section, the term ‘reserves’ means, in connection with an association health plan, plan assets which meet the fiduciary stand-
ards under part 4 and such additional requirements re-
garding liquidity as the applicable authority may prescribe
by regulation.

“(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

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

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

“(C) a representative of the State govern-
ments, or their interests;
“(D) a representative of existing self-insured arrangements, or their interests;

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

“(F) a representative of multiemployer plans that are group health plans, or their interests.

“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

“(a) Filing Fee.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

“(b) Information To Be Included in Application for Certification.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:
“(1) Identifying information.—The names and addresses of—

“(A) the sponsor; and

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

“(2) States in which plan intends to do business.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

“(3) Bonding requirements.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

“(4) Plan documents.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

“(5) Agreements with service providers.—A copy of any agreements between the plan and contract administrators and other service providers.
“(6) **Funding report.**—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

“(A) **Reserves.**—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

“(B) **Adequacy of contribution rates.**—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate,
the statement of actuarial opinion shall indicate
the extent to which the rates are inadequate
and the changes needed to ensure adequacy.

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

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

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

“(c) FILING NOTICE OF CERTIFICATION WITH
STATES.—A certification granted under this part to an
association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

“(d) Notice of Material Changes.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

“(e) Reporting Requirements for Certain Association Health Plans.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the
plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation such interim reports as it considers appropriate.

“(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

“(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

“(2) represent such actuary’s best estimate of anticipated experience under the plan.
The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

“(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

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

“(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.
“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

“(a) Actions To Avoid Depletion of Reserves.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board
shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

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

“(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

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

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recov-
erring for the plan any liability under subsection 
(a)(2)(B)(iii) or (e) of section 806, as necessary to ensure 
that the affairs of the plan will be, to the maximum extent 
possible, wound up in a manner which will result in timely 
provision of all benefits for which the plan is obligated.

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

“(a) Appointment of Secretary as Trustee for 
Insolvent Plans.—Whenever the Secretary determines 
that an association health plan which is or has been cer-
tified under this part and which is described in section 
806(a)(2) will be unable to provide benefits when due or 
is otherwise in a financially hazardous condition, as shall 
be defined by the Secretary by regulation, the Secretary 
shall, upon notice to the plan, apply to the appropriate 
United States district court for appointment of the Sec-
retary as trustee to administer the plan for the duration 
of the insolvency. The plan may appear as a party and 
other interested persons may intervene in the proceedings 
at the discretion of the court. The court shall appoint such 
Secretary trustee if the court determines that the trustee-
ship is necessary to protect the interests of the partici-
pants and beneficiaries or providers of medical care or to
avoid any unreasonable deterioration of the financial con-
dition of the plan. The trusteeship of such Secretary shall
continue until the conditions described in the first sen-
tence of this subsection are remedied or the plan is termi-
nated.

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

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

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

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

“(4) to require the sponsor, the plan adminis-
trator, any participating employer, and any employee
organization representing plan participants to fur-
nish any information with respect to the plan which
the Secretary as trustee may reasonably need in
order to administer the plan;
“(5) to collect for the plan any amounts due the
plan and to recover reasonable expenses of the trust-
eeship;

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

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

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

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

“(10) to do such other acts as may be nec-
essary to comply with this title or any order of the
court and to protect the interests of plan partici-
pants and beneficiaries and providers of medical
care.
“(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary’s appointment as trustee, the Secretary shall give notice of such appointment to—

“(1) the sponsor and plan administrator;
“(2) each participant;
“(3) each participating employer; and
“(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

“(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

“(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

“(f) JURISDICTION OF COURT.—
“(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

“(2) VENUE.—An action under this section may be brought in the judicial district where the
sponsor or the plan administrator resides or does
business or where any asset of the plan is situated.
A district court in which such action is brought may
issue process with respect to such action in any
other judicial district.

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

“SEC. 811. STATE ASSESSMENT AUTHORITY.

“(a) In General.—Notwithstanding section 514, a
State may impose by law a contribution tax on an associa-
tion health plan described in section 806(a)(2), if the plan
commenced operations in such State after the date of the
enactment of the Making Health Care More Affordable

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

“(1) such tax is computed by applying a rate to
the amount of premiums or contributions, with re-
spect to individuals covered under the plan who are
residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

“(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

“(3) such tax is otherwise nondiscriminatory; and

“(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

“(a) DEFINITIONS.—For purposes of this part—
“(1) **GROUP HEALTH PLAN.**—The term ‘group health plan’ has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

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

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

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

“(5) **APPLICABLE AUTHORITY.**—The term ‘applicable authority’ means the Secretary, except that, in connection with any exercise of the Secretary’s authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

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

“(7) **INDIVIDUAL MARKET.**—

“(A) **IN GENERAL.**—The term ‘individual market’ means the market for health insurance
coverage offered to individuals other than in connection with a group health plan.

“(B) Treatment of Very Small Groups.—

“(i) In General.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

“(ii) State Exception.—Clause (I) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

“(8) Participating Employer.—The term ‘participating employer’ means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual
who is such employer (or any dependent, as defined
under the terms of the plan, of such individual) is
or was covered under such plan in connection with
the status of such individual as such an employee,
partner, or self-employed individual in relation to the
plan.

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

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

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

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

“(B) in the case of a sponsor with mem-
ers which consist of associations, a person who
is a member of any such association and elects
an affiliated status with the sponsor, or
“(C) in the case of an association health plan in existence on the date of the enactment of the Making Health Care More Affordable Act of 2008, a person eligible to be a member of the sponsor or one of its member associations.

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

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

“(b) RULES OF CONSTRUCTION.—

“(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—
“(A) in the case of a partnership, the term ‘employer’ (as defined in section 3(5)) includes the partnership in relation to the partners, and the term ‘employee’ (as defined in section 3(6)) includes any partner in relation to the partnership; and

“(B) in the case of a self-employed individual, the term ‘employer’ (as defined in section 3(5)) and the term ‘employee’ (as defined in section 3(6)) shall include such individual.

“(2) Plans, funds, and programs treated as employee welfare benefit plans.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.”.
(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (d)”;

(B) in subsection (b)(5), by striking “subsection (a)” in subparagraph (A) and inserting “subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;)

(C) by redesignating subsection (d) as subsection (e); and

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

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

“(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

“(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as de-
fined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersedes any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

“(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

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

“(B) relating to prompt payment of claims.

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

“(5) For purposes of this subsection, the term ‘association health plan’ has the meaning provided in section 801(a), and the terms ‘health insurance coverage’, ‘participating employer’, and ‘health insurance issuer’ have
the meanings provided such terms in section 812, respectively.”.

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

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

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

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

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

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

(A) by striking “Nothing” and inserting “(1) Except as provided in paragraph (2), nothing”; and
(B) by adding at the end the following new paragraph:

“(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Making Health Care More Affordable Act of 2008 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific reference to the affected section.”.

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

(d) Disclosure of Solvency Protections Related to Self-Insured and Fully Insured Options Under Association Health Plans.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.”.

(e) Savings Clause.—Section 731(e) of such Act is amended by inserting “or part 8” after “this part”.

(f) Report to the Congress Regarding Certification of Self-Insured Association Health Plans.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) Clerical Amendment.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating 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."

SEC. 202. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—
(1) in clause (I), by inserting after “control group,” the following: “except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,”;

(2) in clause (iii), by striking “(iii) the determination” and inserting the following:

“(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under ‘common control’ with another trade or business shall be determined under regulations of the Secretary applying principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, an interest of greater than 25 percent may
not be required as the minimum interest necessary
for common control, or

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

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

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

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

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

(a) Criminal Penalties for Certain Willful
Misrepresentations.—Section 501 of the Employee
is amended—

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

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

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

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

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

“(3) being a plan or arrangement described in
section 3(40)(A)(I),
shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.”.

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

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

“(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

“(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

“(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,
a district court of the United States shall enter an
order requiring that the plan or arrangement cease
activities.

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

“(A) all benefits under it referred to in
paragraph (1) consist of health insurance cov-

erage; and

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

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

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
Section 503 of such Act (29 U.S.C. 1133) is amended by
inserting “(a) IN GENERAL.—” before “In accordance”,
and by adding at the end the following new subsection:
“(b) Association Health Plans.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.”.

SEC. 204. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

“(d) Consultation With States With Respect to Association Health Plans.—

“(1) Agreements with states.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

“(A) the Secretary’s authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

“(B) the Secretary’s authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.
“(2) Recognition of primary domicile state.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

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

“(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.”.

SEC. 205. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) Effective Date.—The amendments made by this title shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 1 year after the date of the enactment of this Act.
(b) Treatment of Certain Existing Health Benefits Programs.—

(1) In General.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income
Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

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

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.
(2) Definitions.—For purposes of this subsection, the terms “group health plan”, “medical care”, and “participating employer” shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an “association health plan” shall be deemed a reference to an arrangement referred to in this subsection.

TITLE III—PURCHASE HEALTH INSURANCE ACROSS STATE LINES

SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) In General.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

“Part D—Cooperative Governing of Individual Health Insurance Coverage

“Definitions

“Sec. 2795.

“In this part:

“(1) Primary State.—The term ‘primary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer,
the State designated by the issuer as the State
whose covered laws shall govern the health insurance
issuer in the sale of such coverage under this part.
An issuer, with respect to a particular policy, may
only designate one such State as its primary State
with respect to all such coverage it offers. Such an
issuer may not change the designated primary State
with respect to individual health insurance coverage
once the policy is issued, except that such a change
may be made upon renewal of the policy. With re-
spect to such designated State, the issuer is deemed
to be doing business in that State.

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

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

“(4) Individual Health Insurance Coverage.—The term ‘individual health insurance coverage’ means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

“(5) Applicable State Authority.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

“(6) Hazardous Financial Condition.—The term ‘hazardous financial condition’ means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

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

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

“(7) Covered Laws.—
“(A) IN GENERAL.—The term ‘covered laws’ means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

“(i) individual health insurance coverage issued by a health insurance issuer;

“(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

“(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

“(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

“(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.
“(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

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

“(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term ‘unfair claims settlement practices’ means only the following practices:

“(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

“(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

“(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.
“(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

“(E) Refusing to pay claims without conducting a reasonable investigation.

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

“(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

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

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

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

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

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

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

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

“(ii) The rating of an insurance policy
or reinsurance contract.
“(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

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

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

“(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

“(vii) The financial condition of an insurer or reinsurer.

“(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

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

“(x) The reinstatement of an insurance policy.

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

“(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

“(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

“APPLICATION OF LAW

“Sec. 2796.

“(a) In General.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

“(b) Exemptions From Covered Laws in a Secondary State.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the
secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

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

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

“(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

“(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer’s financial condition, if—

“(i) the State insurance commissioner of the primary State has not done an examination within the period recommended
by the National Association of Insurance
Commissioners; and

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

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

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

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

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

“(F) to participate, on a nondiscriminatory
basis, in any insurance insolvency guaranty as-
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health insurance issuer in the State is required to belong;

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

“(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

“(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

“(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

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

“(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered
in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned: ‘Notice: This policy is issued by ____________________ and is governed by the laws and regulations of the State of ________________, and it has met all the laws of that State as determined by that State’s Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of ________________, including coverage of some services or benefits mandated by the law of the State of ________________. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of ________________. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.’
“(d) Prohibition on Certain Reclassifications and Premium Increases.—

“(1) In general.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

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

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

“(2) Construction.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

“(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (e) of section 2742;
“(B) from raising premium rates for all policy holders within a class based on claims experience;

“(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

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

“(ii) are based on specific wellness activities that are not applicable to all individuals; and

“(iii) are not obtainable by all individuals to whom coverage is offered;

“(D) from reinstating lapsed coverage; or

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

“(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.
“(f) Licensing of Agents or Brokers for Health Insurance Issuers.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a non-resident agent or broker.

“(g) Documents for Submission to State Insurance Commissioner.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

“(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

“(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

“(B) written notice of any change in its designation of its primary State; and
“(C) written notice from the issuer of the issuer’s compliance with all the laws of the primary State; and

“(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer’s quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

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

“(B) a qualified loss reserve specialist.

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

“(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

“(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in
subparagraphs (A) through (H) of section 2796(b)(1).

“(i) Power of Secondary States To Take Administrative Action.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State’s laws described in section 2796(b)(1).

“(j) State Powers To Enforce State Laws.—

“(1) In general.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

“(2) Courts of competent jurisdiction.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

“(k) States’ Authority To Sue.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

“(l) Generally Applicable Laws.—Nothing in this section shall be construed to affect the applicability
of State laws generally applicable to persons or corpora-
tions.

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

“PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE
ISSUER MAY SELL INTO SECONDARY STATES

“Sec. 2797.

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

“INDEPENDENT EXTERNAL APPEALS PROCEDURES

“Sec. 2798.
“(a) Right to External Appeal.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

“(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

“(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the ‘Health Carrier External Review Model Act’ of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

“(b) Qualifications of Independent Medical Reviewers.—In the case of any independent review mechanism referred to in subsection (a)(2)—
“(1) IN GENERAL.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

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

“(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

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

“(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

“(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

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

“(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

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

“(ii) not have a material familial, financial, or professional relationship with such a party; and

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

“(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

“(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

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

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

“(III) the fact of such an affiliation is disclosed to the issuer and the
enrollee (or authorized representative) and neither party objects; and

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

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

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

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

“(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

“(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteo-
pathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

“(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

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

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

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

“(A) not exceed a reasonable level; and

“(B) not be contingent on the decision rendered by the reviewer.

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

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

“(B) The enrollee (or authorized representative).

“(C) The health care professional that provides the items or services involved in the denial.
“(D) The institution at which the items or services (or treatment) involved in the denial are provided.

“(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

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

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

“(A) ENROLLEE.—The term ‘enrollee’ means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

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

“ENFORCEMENT

“Sec. 2799.

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

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

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

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

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

(c) GAO ONGOING STUDY AND REPORTS.—
(1) STUDY.—The Comptroller General of the
United States shall conduct an ongoing study con-
cerning the effect of the amendment made by sub-
section (a) on—

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

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

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

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

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

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

SEC. 302. SEVERABILITY.

If any provision of the Act or the application of such
provision to any person or circumstance is held to be un-
constitutional, the remainder of this Act and the applica-
tion of the provisions of such to any other person or cir-

 TITLE IV—EXPANSION OF
 HEALTH SAVINGS ACCOUNTS

Subtitle A—Promoting Health for
 Future Generations

SEC. 401. SHORT TITLE.

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

SEC. 402. INCREASE IN HSA CONTRIBUTION LIMITATION.

(a) In General.—Subsection (b) of section 223 of
the Internal Revenue Code of 1986 (relating to monthly
limitation) is amended—

(1) by striking “$2,250” in paragraph (2)(A)
and inserting “the amount in effect under subsection
(e)(2)(A)(ii)(I)”, and

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

(b) Conforming Amendment.—Paragraph (1) of
section 223(g) of such Code is amended by striking “sub-
sections (b)(2)” and inserting “subsection”.

(c) Effective Date.—The amendments made by
this section shall apply to contributions in taxable years
beginning after December 31, 2008.
SEC. 403. MEDICARE AND VA HEALTHCARE ENROLLEES ELIGIBLE TO CONTRIBUTE TO HSA.

(a) In General.—(1) Subsection (b) of section 223 of the Internal Revenue Code of 1986 is amended by striking paragraph (7).

(2) Subsection (c) of section 223 of such Code (relating to definitions and special rules) is amended by adding at the end to following new paragraph:

“(6) Special rule for individuals entitled to benefits under Medicare or enrolled for health benefits from VA.—In the case of an individual—

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

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

“(B)(i) who is enrolled in the patient enrollment system established by the Secretary of Veterans Affairs pursuant to section 1705 of title 38, United States Code, and

“(ii) with respect to whom a health savings account is established in a month before the first month such individual is enrolled in such system,
such individual shall be deemed to be an eligible indi-

dividual.”.

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

SEC. 404. EXPANDING ADDITIONAL CONTRIBUTIONS LIMIT-
ATION.

(a) IN GENERAL.—

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

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

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

(b) EFFECTIVE DATE.—The amendment made by
this section shall apply to taxable years beginning after
December 31, 2008.
SEC. 405. ELIGIBILITY TO CONTRIBUTE TO HSA.

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

“(C) SPECIAL RULE FOR CERTAIN FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual is covered under a flexible spending arrangement (within the meaning of section 106(c)(2)) which is maintained by an employer of the spouse of the individual, but only if—

“(i) the employer is not also the employer of the individual, and

“(ii) the individual certifies to the employer and to the Secretary (in such form and manner as the Secretary may prescribe) that the individual and the individual’s spouse will not accept reimbursement under the arrangement for any expenses for medical care provided to the individual.”.
(b) **Effective Date.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

**SEC. 406. DEDUCTION OF PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.**

(a) **In General.**—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

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“SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

“(a) Deduction Allowed.—In the case of an individual, there shall be allowed as a deduction for the taxable year the aggregate amount paid by the taxpayer as premiums under a high deductible health plan with respect to months during such year for which such individual is an eligible individual with respect to such health plan.

“(b) Definitions.—For purposes of this section—

“(1) Eligible Individual.—The term ‘eligible individual’ means an individual who—

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

“(B) is the taxpayer or the taxpayer’s spouse and dependents.
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“(2) High deductible health plan.—The term ‘high deductible health plan’ has the meaning given such term by section 223(c)(2).

“(c) Special rules.—

“(1) Deduction limits.—

“(A) Deduction allowable for only 1 plan.—For purposes of this section, in the case of an individual covered by more than 1 high deductible health plan for any month, the individual may only take into account amounts paid for such month for the plan with the lowest premium.

“(B) Plans covering ineligible individuals.—If 2 or more individuals are covered by a high deductible health plan for any month but only 1 of such individuals is an eligible individual for such month, only 50 percent of the aggregate amount paid by such eligible individual as premiums under the plan with respect to such month shall be taken into account for purposes of this section.

“(2) Group health plan coverage.—

“(A) In general.—No deduction shall be allowed for an individual under subsection (a) for any amount paid for coverage under a high
deductible health plan for a month if that individual participates in any coverage under a group health plan (within the meaning of section 5000 without regard to section 5000(d)). For purposes of the preceding sentence, an arrangement which constitutes individual health insurance shall not be treated as a group health plan if such arrangement is a high deductible health plan (as defined in section 223(c)(2)), or is a payment by an employer or employee organization with respect to such high deductible health plan, notwithstanding that an employer or employee organization negotiates the cost or benefits of such arrangement.

“(B) Exception for Plans Only Providing Contributions to Health Savings Accounts.—Subparagraph (A) shall not apply to an individual if the individual’s only coverage under a group health plan for a month consists of contributions by an employer to a health savings account with respect to which the individual is the account beneficiary.

“(C) Exception for Certain Permitted Coverage.—Subparagraph (A) shall not apply to an individual if the individual’s
only coverage under a group health plan for a month is coverage described in clause (i) or (ii) of section 223(c)(1)(B).

“(3) Medical and Health Savings Accounts.—Subsection (a) shall not apply with respect to any amount which is paid or distributed out of an Archer MSA or a health savings account which is not included in gross income under section 220(f) or 223(f), as the case may be.

“(4) Coordination with Deduction for Health Insurance of Self-Employed Individuals.—Any amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

“(5) Coordination with Medical Expense Deduction.—Any amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213.”.

(b) Deduction Allowed Whether or Not Individual Itemizes Other Deductions.—Subsection (a) of section 62 of such Code is amended by inserting before the last sentence at the end the following new paragraph:
“(22) Premiums for high deductible health plans.—The deduction allowed by section 224.”.

(e) Coordination With Section 35 Health Insurance Costs Credit.—Section 35(g)(2) of such Code (relating to coordination with other deductions) is amended by striking “or 213” and inserting “, 213, or 224”.

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

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

(e) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

SEC. 407. MSA PLAN DEDUCTIBLE EXCEPTION FOR PREVENTIVE CARE.

(a) In General.—Paragraph (3) of section 1859(b) of the Social Security Act (42 U.S.C. 1359w–28(b)) is amended by adding at the end the following new subparagraph:

“(C) Exception for absence of preventive care deductible.—A plan shall not fail to be treated as a MSA plan by reason of failing to have a deductible for preventive care

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(within the meaning of such term as applied for purposes of section 223(e)(2)(C) of the Internal Revenue Code of 1986).’’.

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

SEC. 408. PERMITTING INDIVIDUAL CONTRIBUTIONS TO MEDICARE ADVANTAGE MSA.

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

“(C) any contributions by or for the benefit of the account holder (other than a contribution described in subparagraph (A)) for the taxable year, the sum of which do not exceed the difference of—

“(i) the amount of the annual deductible (described in section 1859(b)(3)(B) of the Social Security Act) for the MSA plan in which the individual is enrolled, over

“(ii) the amount of contributions described in subparagraph (A) for the taxable year,”.

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(b) **Effective Date.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2008.

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

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

(A) by inserting “or adult child” after “surviving spouse”,

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

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

(2) Paragraph (8) of section 220(f) of such Code is amended by adding at the end the following new subparagraph:

“(C) **ADULT CHILD.**—For purposes of this paragraph, the term ‘adult child’ means an individual—

“(i) who is a child of the deceased individual, and

“(ii) with respect to whom a deduction under section 151 would not be allowable to another taxpayer for a taxable year
beginning in the calendar year in which such individual’s taxable year begins.”.

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

(A) by inserting “or adult child” after “surviving spouse”,

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

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

(2) Paragraph (8) of section 223(f) of such Code is amended by adding at the end the following new subparagraph:

“(C) ADULT CHILD.—For purposes of this paragraph, the term ‘adult child’ has the meaning given to such term by section 220(f)(8)(C).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.
SEC. 410. PERMITTING MEDICARE ADVANTAGE MSA FUNDS TO BE USED FOR WELLNESS AND FITNESS PROGRAMS.

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

“(C) qualified medical expenses shall include amounts paid to a gym for enrollment in a wellness or fitness program.”.

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2008.

SEC. 411. HEALTH REIMBURSEMENT ARRANGEMENTS AND SPENDING ARRANGEMENTS IN COMBINATION WITH HEALTH SAVINGS ACCOUNTS.

(a) In General.—Subparagraph (B) of section 223(c)(1) of the Internal Revenue Code of 1986 (relating to certain coverage disregarded) is amended by striking “and” at the end of clause (ii), by striking the period at the end of clause (iii) and inserting “, and”, and by inserting after clause (iii) the following new clause:

“(iv) coverage under a flexible spending arrangement or a health reimburse-
ment arrangement, or both, which meets
the requirements of paragraph (7).”.

(b) Combination Health Reimbursement, Sav-
ings, and Spending Arrangements.—Subsection (c) of
section 223 of such Code (relating to definitions and spe-
cial rules), as amended by this Act, is amended by adding
at the end the following new paragraph:

“(7) Combined limit for contributions or
credits to health reimbursement, arrange-
ments and spending arrangements.—

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

“(i) the sum of—

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

“(II) the salary reduction
amount elected by the individual and,
if applicable, the employer contribu-
tion or credit allocated to the indi-
vidual for the taxable year under the
flexible spending arrangement (as de-
fined in section 106(c)(2)), plus
“(III) the amounts that the individual is permitted, under the terms of the plan, to receive in reimbursements for the taxable year under the health reimbursement arrangement, does not exceed

“(ii) the sum of the annual deductible and the other annual out-of-pocket expenses (other than for premiums) required to be paid under the plan by the eligible individual for covered benefits.

“(B) Exceptions for disregarded coverage.—For purposes of subparagraph (A)—

“(i) Certain flexible spending arrangements.—Any flexible spending arrangement salary reduction amounts or employer contributions or credits that are restricted by the employer to use for coverage described in paragraph (1)(B) shall not be taken into account under subparagraph (A)(i)(II).

“(ii) Certain health reimbursement arrangements.—Any reimbursements from a health reimbursement arrangement for coverage described in para-
graph (1)(B) shall not be taken into account under subparagraph (A)(i)(III).

“(iii) QUALIFIED HSA DISTRIBUTIONS FROM FSA AND HRA TERMINATIONS.—Any qualified HSA distribution (as defined in section 106(e)) shall not be taken into account under subparagraph (A)(i).

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

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

SEC. 412. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.

(a) IN GENERAL.—Subsection (d) of section 223 of the Internal Revenue Code of 1986 is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

“(4) CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS QUALIFIED.—
“(A) IN GENERAL.—For purposes of paragraph (2), an expense shall not fail to be treated as a qualified medical expense solely because such expense was incurred before the establishment of the health savings account if such expense was incurred during the 60-day period beginning on the date on which the high deductible health plan is first effective.

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

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

“(ii) the effective date of the health savings account is deemed to be the date on which the high deductible health plan is first effective after the date of the enactment of this paragraph.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to insurance pur-
chased after December 31, 2008, in taxable years begin-
ing after such date.

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

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

“(C) SPECIAL RULE WHERE BOTH
spouses are eligible individuals with 1
account.—If—

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

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

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

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

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

(a) GRACE PERIOD NOT REQUIRED.—Section
106(e)(2) of the Internal Revenue Code of 1986 is amend-
ed by adding at the end the following new sentence: “A distribution shall not fail to be treated as a qualified HSA distribution merely because the balance in such arrangement is determined without regard to the requirement that unused amounts remaining at the end of a plan year must be forfeited in the absence of a grace period.”.

(b) Deposit in Limited FSA or HRA of Funds in Excess FSA or HRA Termination Distribution.—Paragraph (1) of section 106(e) of such Code is amended by inserting before the period at the end thereof the following: “and the deposit of funds in excess of a qualified HSA distribution amount into a health flexible spending account or health reimbursement arrangement which is compatible with a health savings account and which, on the date of such distribution, is a part of the employer’s plan”.

(c) Disclaimer of Disqualifying Coverage.—Subparagraph (B) of section 223(c)(1) of such Code, as amended by this Act, is amended by striking “and” at the end of clause (iii), by striking the period at the end of clause (iv) and inserting “, and”, and by inserting after clause (iv) the following new clause:

“(v) any coverage (whether actual or prospective) otherwise described in subparagraph (A)(ii) which is disclaimed at
the time of the creation or organization of
the health savings account.”.

(d) Effective Date.—The amendments made by
this section shall apply to taxable years beginning after
December 31, 2008.

Subtitle B—Increased Access to
Health Insurance Through HSAs

SEC. 421. SHORT TITLE.

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

SEC. 422. PURCHASE OF HEALTH INSURANCE FROM
HEALTH SAVINGS ACCOUNTS.

(a) In General.—Paragraph (2) of section 223(d)
of the Internal Revenue Code of 1986 (defining qualified
medical expenses) is amended to read as follows:

“(2) Qualified medical expenses.—The
term ‘qualified medical expenses’ means, with re-
spect to an account beneficiary, amounts paid by
such beneficiary for medical care (as defined in sec-
section 213(d)) for such individual, the spouse of such
individual, and any dependent (as defined in section
152, determined without regard to subsections
(b)(1), (b)(2), and (d)(1)(B) thereof) of such indi-
vidual, but only to the extent such amounts are not
compensated for by insurance or otherwise.”.
(b) **Effective Date.**—The amendment made by this section shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years beginning after such date.

**TITLE V—HEALTH CARE TORT REFORM**

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

(a) **Findings.**—

(1) **Effect on health care access and costs.**—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) **Effect on interstate commerce.**—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to
the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) Effect on Federal Spending.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

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

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) Purpose.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;
(2) reduce the incidence of “defensive medicine” and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

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

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 502. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—
(1) upon proof of fraud;
(2) intentional concealment; or
(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

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

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

(a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any health care lawsuit, nothing in this title shall limit a claimant’s recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

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

(c) No Discount of Award for Noneconomic Damages.—For purposes of applying the limitation in
subsection (b), future noneconomic damages shall not be
discounted to present value. The jury shall not be in-
formed about the maximum award for noneconomic dam-
ages. An award for noneconomic damages in excess of
$250,000 shall be reduced either before the entry of judg-
ment, or by amendment of the judgment after entry of
judgment, and such reduction shall be made before ac-
counting for any other reduction in damages required by
law. If separate awards are rendered for past and future
noneconomic damages and the combined awards exceed
$250,000, the future noneconomic damages shall be re-
duced first.

(d) Fair Share Rule.—In any health care lawsuit,
each party shall be liable for that party’s several share
of any damages only and not for the share of any other
person. Each party shall be liable only for the amount of
damages allocated to such party in direct proportion to
such party’s percentage of responsibility. Whenever a
judgment of liability is rendered as to any party, a sepa-
rate judgment shall be rendered against each such party
for the amount allocated to such party. For purposes of
this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant’s harm.

SEC. 504. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

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

(2) 33 1⁄3 percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).
(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 505. ADDITIONAL HEALTH TORT REFORM BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled
as well as a health care lawsuit that is resolved by a fact
finder. This section shall not apply to section 1862(b) (42
1396a(a)(25)) of the Social Security Act.

SEC. 506. PUNITIVE DAMAGES.

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

(1) whether punitive damages are to be awarded and the amount of such award; and

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

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

(b) Determining Amount of Punitive Damages.—

(1) Factors Considered.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

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

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

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

(D) the number of products sold or medical procedures rendered for compensation, as
the case may be, by such party, of the kind causing the harm complained of by the claimant;

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

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

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

(e) NO PUNITIVE DAMAGES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant’s harm where—
(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant’s harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.
(B) **Rule of Construction.**—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) **Liability of Health Care Providers.**—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) **Packaging.**—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Serv-
ices (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

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

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is causally related to the harm which the claimant allegedly suffered; or

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.
SEC. 507. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) In general.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) Applicability.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 508. DEFINITIONS.

In this title:

(1) Alternative dispute resolution system; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.
(2) CLAIMANT.—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term “collateral source benefits” means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers’ compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

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

(D) any other publicly or privately funded
program.

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

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

(6) Economic Damages.—The term “economic damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) Health Care Lawsuit.—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plain-
tiffs, defendants, or other parties, or the number of
claims or causes of action, in which the claimant al-
leges a health care liability claim. Such term does
not include a claim or action which is based on
criminal liability; which seeks civil fines or penalties
paid to Federal, State, or local government; or which
is grounded in antitrust.

(8) Health Care Liability Action.—The
term “health care liability action” means a civil ac-
tion brought in a State or Federal court or pursuant
to an alternative dispute resolution system, against
a health care provider, a health care organization, or
the manufacturer, distributor, supplier, marketer,
promoter, or seller of a medical product, regardless
of the theory of liability on which the claim is based,
or the number of plaintiffs, defendants, or other par-
ties, or the number of causes of action, in which the
claimant alleges a health care liability claim.

(9) Health Care Liability Claim.—The
term “health care liability claim” means a demand
by any person, whether or not pursuant to ADR,
against a health care provider, health care organiza-
tion, or the manufacturer, distributor, supplier, mar-
keter, promoter, or seller of a medical product, in-
cluding, but not limited to, third-party claims, cross-
claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term “health care organization” means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term “health care provider” means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term “health care goods or services” means any goods or services provided by a health care organization, provider, or by any individual working under
the supervision of a health care provider, that relates
to the diagnosis, prevention, or treatment of any
human disease or impairment, or the assessment or
care of the health of human beings.

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

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

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

(16) **PUNITIVE DAMAGES.**—The term “punitive damages” means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) **RECOVERY.**—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) **STATE.**—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and
any other territory or possession of the United States, or any political subdivision thereof.

SEC. 509. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.
SEC. 510. STATE FLEXIBILITY AND PROTECTION OF STATES’ RIGHTS.

(a) Health Care Lawsuits.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) Protection of States’ Rights and Other Laws.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

(c) State Flexibility.—No provision of this title
shall be construed to preempt—

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

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

SEC. 511. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit
brought in a Federal or State court, or subject to an alter-
native dispute resolution system, that is initiated on or
after the date of the enactment of this Act, except that
any health care lawsuit arising from an injury occurring
prior to the date of the enactment of this Act shall be
governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SEC. 512. SENSE OF CONGRESS.

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

TITLE VI—HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 601. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure for the secure and authorized exchange and use of healthcare information.

SEC. 602. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations to provide for the certification and auditing of the banking of electronic medical records.
(b) General Rights.—An individual who has a
health record contained in a health record bank shall
maintain ownership over the health record and shall have
the right to review the contents of the record.

SEC. 603. APPLICATION OF FEDERAL AND STATE SECURITY
AND CONFIDENTIALITY STANDARDS.

(a) In General.—Current Federal security and confi-
didentiality standards and State security and confidentiality laws shall apply to this subtitle until such time as
Congress acts to amend such standards.

(b) Definitions.—In this section:

(1) Current Federal security and confidentiality standards.—The term “current
Federal security and confidentiality standards” means the Federal privacy standards established
pursuant to section 264(c) of the Health Insurance
Portability and Accountability Act of 1996 (42
U.S.C. 1320d–2 note) and security standards estab-
lished under section 1173(d) of the Social Security
Act (42 U.S.C. 1320d–2(d)).

(2) State security and confidentiality
laws.—The term “State security and confidentiality
laws” means State laws and regulations relating to
the privacy and confidentiality of individually identi-
fiable health information or to the security of such information.

(3) State.—The term “State” has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

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.

(a) For Civil Penalties.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

“(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.”; and

(2) in subsection (i), by adding at the end the following new paragraph:
“(8) The term ‘health information technology’ means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.”.

(b) For Criminal Penalties.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (G), by striking “and” at the end;

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);
(ii) by moving such subparagraph 2

e ms to the left; and

(iii) by striking the period at the end

and inserting “; and”; and

(D) by adding at the end the following new

subparagraph:

“(J) any nonmonetary remuneration (in the

form of health information technology, as defined in

section 1128A(i)(8), or related installation, mainte-
nance, support or training services) made to a per-

son by a specified entity (as defined in subsection

(g)) if—

“(i) the provision of such remuneration is

without an agreement between the parties or

legal condition that—

“(I) limits or restricts the use of the

health information technology to services

provided by the physician to individuals re-

ceiving services at the specified entity;

“(II) limits or restricts the use of the

health information technology in conjunc-
tion with other health information tech-

nology; or
“(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

“(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration solicited or received (or offered or paid) and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

“(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.”; and

(2) by adding at the end the following new subsection:

“(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term ‘specified entity’ means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering
the goals and objectives of this section, as well as the goals
to better coordinate the delivery of health care and to pro-
mote the adoption and use of health information tech-
nology.”.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made
by subsections (a) and (b) shall take effect on the
date that is 120 days after the date of the enact-
ment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State
(as defined in section 1101(a) of the Social Security
Act (42 U.S.C. 1301(a)) for purposes of title XI of
such Act) shall have in effect a State law that im-
poses a criminal or civil penalty for a transaction de-
scribed in section 1128A(b)(4) or section
1128B(b)(3)(J) of such Act, as added by subsections
(a)(1) and (b), respectively, if the conditions de-
scribed in the respective provision, with respect to
such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF
SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and
Human Services shall conduct a study to determine
the impact of each of the safe harbors described in
paragraph (3). In particular, the study shall examine
the following:

(A) The effectiveness of each safe harbor
in increasing the adoption of health information
technology.

(B) The types of health information tech-
nology provided under each safe harbor.

(C) The extent to which the financial or
other business relationships between providers
under each safe harbor have changed as a re-
sult of the safe harbor in a way that adversely
affects or benefits the health care system or
choices available to consumers.

(D) The impact of the adoption of health
information technology on health care quality,
cost, and access under each safe harbor.

(2) REPORT.—Not later than 3 years after the
effective date described in subsection (e)(1), the Sec-
ritary of Health and Human Services shall submit
to Congress a report on the study under paragraph
(1).

(3) SAFE HARBORS DESCRIBED.—For purposes
of paragraphs (1) and (2), the safe harbors de-
scribed in this paragraph are—
(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 612. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

“(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

“(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

“(i) the provision of such remuneration is without an agreement between the parties or legal condition that—
“(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

“(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

“(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

“(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

“(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of
any hardware or software component of
such remuneration that would permit
interoperability.

“(B) Health information technology
defined.—For purposes of this paragraph, the
term ‘health information technology’ means
hardware, software, license, right, intellectual
property, equipment, or other information tech-
nology (including new versions, upgrades, and
connectivity) designed or provided primarily for
the electronic creation, maintenance, or ex-
change of health information to better coordi-
nate care or improve health care quality, effi-
ciency, or research.

“(C) Specified entity defined.—For
purposes of this paragraph, the term ‘specified
entity’ means an entity that is a hospital, group
practice, prescription drug plan sponsor, a
Medicare Advantage organization, or any other
such entity specified by the Secretary, consid-
ering the goals and objectives of this section, as
well as the goals to better coordinate the deliv-
ery of health care and to promote the adoption
and use of health information technology.”.

(b) Effective Date; Effect on State Laws.—
• The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) Preemption of State Laws.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) Study and Report To Assess Effect of Exception on Health System.—

(1) In General.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.
(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 613. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 611(b)(1), the following: “For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, em-
ployers, and other interested entities to collectively pur-
chase and donate health information technology, or from
offering health care providers a choice of health informa-
tion technology products in order to take into account the
varying needs of such providers receiving such products.”.

(b) APPLICATION TO STARK EXCEPTION.—Para-
graph (6) of section 1877(b) of the Social Security Act
(42 U.S.C. 1395nn(b)), as added by section 612(a), is
amended by adding at the end the following new subpara-
graph:

“(D) RULE OF CONSTRUCTION.—For pur-
poses of subparagraph (A), nothing in such
subparagraph shall be construed as preventing
a specified entity, consistent with the specific
requirements of such subparagraph, from—

“(i) forming a consortium composed
of health care providers, payers, employers,
and other interested entities to collectively
purchase and donate health information
technology; or

“(ii) offering health care providers a
choice of health information technology
products in order to take into account the
varying needs of such providers receiving such products.”.