

**AMENDMENT TO MOTION****OFFERED BY MR. ROGERS OF MICHIGAN**

In lieu of the additional recommended amendments in the Motion, insert the following additional recommended amendment:

Strike all after the enacting clause and insert the following:

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

2 (a) **SHORT TITLE.**—This Act may be cited as the  
3 “American Health Care Solutions Act of 2009”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Rule of construction regarding prohibition on authority to ration health care.

**TITLE I—EXPANDING ACCESS TO COVERAGE****Subtitle A—Protecting Affordability Through Reinsurance or High Risk Pooling**

Sec. 101. Ensuring affordability for all through special pooling of cost for those with pre-existing conditions and many health care needs.

**Subtitle B—Individual Membership Associations**

Sec. 111. Expansion of access and choice of health insurance coverage through individual membership associations (IMAs).

**Subtitle C—Association Health Plans**

Sec. 121. Rules governing association health plans.

Sec. 122. Clarification of treatment of single employer arrangements.

Sec. 123. Enforcement provisions relating to association health plans.

Sec. 124. Cooperation between Federal and State authorities.

Sec. 125. Effective date and transitional and other rules.

**Subtitle D—Purchasing Insurance Across State Lines**

Sec. 131. Cooperative governing of individual health insurance coverage.

Sec. 132. Severability.

**Subtitle E—Protecting Patients From Rescissions**

Sec. 141. Opportunity for independent, external third party reviews of certain nonrenewals and discontinuations, including rescissions, of individual health insurance coverage.

**TITLE II—PROMOTING PATIENT CHOICE****Subtitle A—Credit for Small Employers Adopting Auto-Enrollment and Defined Contribution Options**

Sec. 201. Credit for small employers adopting auto-enrollment and defined contribution options.

**Subtitle B—Tax Incentives for Long-Term Care Insurance**

Sec. 211. Treatment of premiums on qualified long-term care insurance contracts.

Sec. 212. Credit for taxpayers with long-term care needs.

Sec. 213. Additional consumer protections for long-term care insurance.

**Subtitle C—Comparative Effectiveness Research**

Sec. 221. Prohibition on Certain Uses of Data Obtained from Comparative Effectiveness Research; Accounting for Personalized Medicine and Differences in Patient Treatment Response.

**Subtitle D—Programs of Health Promotion or Disease Prevention**

Sec. 231. Programs of health promotion or disease prevention.

**TITLE III—STRENGTHENING SAFETY NET PROGRAMS****Subtitle A—Beneficiary Choice Under Medicaid and SCHIP**

Sec. 301. Easing administrative barriers to State cooperation with employer-sponsored insurance coverage.

Sec. 302. Improving beneficiary choice in SCHIP.

Sec. 303. Application to Medicaid.

Sec. 304. Expansion of health opportunity account program.

Sec. 305. Verification requirements to prevent illegal aliens from receiving Medicaid benefits.

**Subtitle B—Community Health Centers**

Sec. 311. Increased funding.

**TITLE IV—EXPANDING HEALTH SAVINGS ACCOUNTS**

Sec. 401. Allow both spouses to make catch-up contributions to the same HSA account.

Sec. 402. Provisions relating to Medicare.

Sec. 403. Individuals eligible for veterans benefits for a service-connected disability.

Sec. 404. Individuals eligible for Indian Health Service assistance.

- Sec. 405. FSA and HRA termination to fund HSAS.
- Sec. 406. Purchase of health insurance from HSA account.
- Sec. 407. Special rule for certain medical expenses incurred before establishment of account.
- Sec. 408. Preventive care prescription drug clarification.
- Sec. 409. Qualified medical expenses.

**TITLE V—MEDICAL LIABILITY REFORM**

**Subtitle A—Medical Liability**

- Sec. 501. Encouraging speedy resolution of claims.
- Sec. 502. Compensating patient injury.
- Sec. 503. Maximizing patient recovery.
- Sec. 504. Additional health benefits.
- Sec. 505. Punitive damages.
- Sec. 506. Authorization of payment of future damages to claimants in HEALTH care lawsuits.
- Sec. 507. Definitions.
- Sec. 508. Effect on other laws.
- Sec. 509. State flexibility and protection of states' rights.
- Sec. 510. Applicability; effective date.
- Sec. 511. Sense of Congress.

**Subtitle B—Liability Protection for Community Health Center Volunteers**

- Sec. 521. Health centers under Public Health Service Act; liability protections for volunteer practitioners.

**TITLE VI—MISCELLANEOUS**

**Subtitle A—Provide Adequate Funding to HHS OIG and HCFAC**

- Sec. 601. Provide adequate funding to HHS OIG and HCFAC.

**Subtitle B—State Transparency Plan Portal**

- Sec. 611. Providing information on health coverage options and health care providers.
- Sec. 612. Establishment of performance-based quality measures.

**Subtitle C—Medicare Accountable Care Organization Demonstration Program**

- Sec. 621. Medicare Accountable Care Organization demonstration program.

**Subtitle D—Repeal of Unused Stimulus Funds**

- Sec. 631. Rescission and repeal in ARRA.

**1 SEC. 2. RULE OF CONSTRUCTION REGARDING PROHIBITION ON AUTHORITY TO RATION HEALTH CARE.**

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3  
4 Nothing in this Act may be construed to authorize  
5 the Federal Government to ration health care for the  
6 American people.

**7 TITLE I—EXPANDING ACCESS TO COVERAGE**

**8 Subtitle A—Protecting Affordability Through Reinsurance or High Risk Pooling**

**9 SEC. 101. ENSURING AFFORDABILITY FOR ALL THROUGH SPECIAL POOLING OF COST FOR THOSE WITH PRE-EXISTING CONDITIONS AND MANY HEALTH CARE NEEDS.**

**10 (a) STATE REQUIREMENT.—**

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17 (1) IN GENERAL.—Not later than 2 years after  
18 the date of the enactment of this Act, each State  
19 shall ensure an adequate financial backstop to mitigate the cost of high risk individuals in the State  
20 through—  
21

22 (A) a qualified State reinsurance program  
23 described in subsection (b); or

24 (B) a qualifying State high risk pool described in subsection (c)(1); and  
25

1 (C) subject to paragraph (4), contribute to  
 2 the ongoing stability of the arrangement  
 3 through State assessments or allocation of  
 4 other State funds that are not otherwise used  
 5 on State health care programs.

6 (2) PREFERENCE.—Beginning 3 years after the  
 7 date of the enactment of this Act, the Secretary, in  
 8 awarding any competitive grant and for which only  
 9 States are eligible to apply, shall give preference to  
 10 a State with a program that meets the requirements  
 11 of paragraph (1).

12 (3) RELATION TO CURRENT QUALIFIED HIGH  
 13 RISK POOL PROGRAM OPERATING A QUALIFIED HIGH  
 14 RISK POOL.—In the case of a State that is operating  
 15 a current section 2745 qualified high risk pool as of  
 16 the date of the enactment of this Act—

17 (A) as of the date that is 2 years after the  
 18 date of the enactment of this Act, such a pool  
 19 shall not be treated as a qualified high risk pool  
 20 under section 2745 of the Public Health Service  
 21 Act (42 U.S.C. 300gg-45) unless the pool is a  
 22 qualifying State high risk pool described in sub-  
 23 section (e)(1); and

24 (B) current funding sources may be used  
 25 to transition from operation of such a pool to

1 operation of a qualified State reinsurance pro-  
 2 gram described in subsection (b).

3 (4) APPLICATION OF FUNDS.—If the program  
 4 or pool operated under paragraph (1)(A) is in sound  
 5 financial condition as demonstrated by audited fi-  
 6 nancial statements and actuarial certification and is  
 7 approved as an appropriate financial backstop by the  
 8 State Insurance Commissioner involved, the require-  
 9 ment of paragraph (1)(C) shall be waived.

10 (b) QUALIFIED STATE REINSURANCE PROGRAM.—

11 (1) FORM OF PROGRAM.—A qualified State re-  
 12 insurance program may provide reinsurance—

13 (A) on a prospective or retrospective basis;  
 14 and

15 (B) on a basis that protects health insur-  
 16 ance issuers against the annual aggregate  
 17 spending of their enrollees as well as purchase  
 18 protection against individual catastrophic costs.

19 (2) SATISFACTION OF HIPAA REQUIREMENT.—  
 20 A qualified State reinsurance program shall be  
 21 deemed, for purposes of section 2745 of the Public  
 22 Health Service Act (42 U.S.C. 300gg-45), to be a  
 23 qualified high-risk pool under such section.

24 (c) QUALIFYING STATE HIGH RISK POOL.—

1 (1) IN GENERAL.—A qualifying State high risk  
2 pool described in this subsection means a current  
3 section 2745 qualified high risk pool that meets the  
4 following requirements:

5 (A) The pool offers assistance to low-in-  
6 come individuals as applicable and may incor-  
7 porate applicable federal and State programs  
8 for eligible individuals to meet this purpose.

9 (B) The pool provides a variety of coverage  
10 options, one of which must be a high deductible  
11 health plan that may be coupled with a health  
12 savings account.

13 (C) The pool is funded with a stable fund-  
14 ing source that is not solely dependent on an  
15 appropriation from a State legislature.

16 (D) The pool eliminates waiting lists and  
17 pre-existing conditions exclusionary periods so  
18 that all eligible residents who are seeking cov-  
19 erage through the pool can receive coverage  
20 through the pool.

21 (E) The pool allows for coverage of individ-  
22 uals who, but for the 24-month disability wait-  
23 ing period under section 226(b) of the Social  
24 Security Act, would be eligible for Medicare  
25 during the period of such waiting period.

1 (F) The pool does not charge participants  
2 more than 150 percent of the average premium  
3 for individual market coverage in that State.

4 (G) The pool conducts education and out-  
5 reach initiatives so that residents and brokers  
6 understand that the pool is available to eligible  
7 residents.

8 (H) The pool does not impose lifetime or  
9 annual limits on benefits.

10 (2) RELATION TO SECTION 2745.—As of the  
11 date that is 2 years after the date of the enactment  
12 of this Act, a pool shall not qualify as a qualified  
13 high risk pool under section 2745 of the Public  
14 Health Service Act (42 U.S.C. 300gg–45) unless the  
15 pool is a qualifying State high risk pool described in  
16 paragraph (1).

17 (d) WAIVERS.—In order to accommodate new and in-  
18 novative programs, the Secretary may waive such require-  
19 ments of this section for qualified State reinsurance pro-  
20 grams and for qualifying State high risk pools as the Sec-  
21 retary deems appropriate.

22 (e) FUNDING.—In addition to any other amounts ap-  
23 propriated, there are authorized to be appropriated to  
24 carry out section 2745 of the Public Health Service Act  
25 (42 U.S.C. 300gg–45) (including through a program or

1 pool described in subsection (a)(1), \$20,000,000,000 for  
2 Fiscal Years 2010 through 2019 to carry out this section.

3 (f) DEFINITIONS.—In this section:

4 (1) CURRENT SECTION 2745 QUALIFIED HIGH  
5 RISK POOL.—The term “current section 2745 quali-  
6 fied high risk pool” has the meaning given the term  
7 “qualified high risk pool” under section 2745(g) of  
8 the Public Health Service Act (42 U.S.C. 300gg-  
9 45(g)) as in effect as of the date of the enactment  
10 of this Act.

11 (2) HEALTH INSURANCE COVERAGE.—The term  
12 “health insurance coverage” has the meaning given  
13 such term in section 2791 of the Public Health  
14 Service Act (42 U.S.C. 300gg-91).

15 (3) HEALTH INSURANCE ISSUER.—The term  
16 “health insurance issuer” has the meaning given  
17 such term in section 2791 of the Public Health  
18 Service Act (42 U.S.C. 300gg-91).

19 (4) QUALIFIED STATE REINSURANCE PRO-  
20 GRAM.—The term “qualified State reinsurance pro-  
21 gram” means a program operated by a State or a  
22 State authorized program that provides reinsurance  
23 for health insurance coverage offered in the indi-  
24 vidual or the small group market in accordance with

1 the model for such a program established (as of the  
2 date of the enactment of this Act).

3 (5) SECRETARY.—The term “Secretary” means  
4 the Secretary of Health and Human Services.

5 (6) STATE.—The term “State” has the mean-  
6 ing given such term for purposes of title XIX of the  
7 Social Security Act.

## 8 **Subtitle B—Individual Membership** 9 **Associations**

### 10 **SEC. 111. EXPANSION OF ACCESS AND CHOICE OF HEALTH** 11 **INSURANCE COVERAGE THROUGH INDI-** 12 **VIDUAL MEMBERSHIP ASSOCIATIONS (IMAS).**

13 The Public Health Service Act (42 U.S.C. 201 et  
14 seq.) is amended by adding at the end the following new  
15 title:

## 16 **“TITLE XXXI—INDIVIDUAL** 17 **MEMBERSHIP ASSOCIATIONS**

### 18 **“SEC. 3101. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-** 19 **SOCIATION (IMA).**

20 “(a) IN GENERAL.—For purposes of this title, the  
21 terms ‘individual membership association’ and ‘IMA’  
22 mean a legal entity that meets the following requirements:

23 “(1) ORGANIZATION.—The IMA is an organiza-  
24 tion operated under the direction of an association  
25 (as defined in section 3104(1)).

1           “(2) OFFERING HEALTH BENEFITS COV-  
2 ERAGE.—

3           “(A) DIFFERENT GROUPS.—The IMA, in  
4 conjunction with those health insurance issuers  
5 that offer health benefits coverage through the  
6 IMA, makes available health benefits coverage  
7 in the manner described in subsection (b) to all  
8 members of the IMA and the dependents of  
9 such members in the manner described in sub-  
10 section (c)(2) at rates that are established by  
11 the health insurance issuer on a policy or prod-  
12 uct specific basis and that may vary only as  
13 permissible under State law.

14           “(B) NONDISCRIMINATION IN COVERAGE  
15 OFFERED.—

16           “(i) IN GENERAL.—Subject to clause  
17 (ii), the IMA may not offer health benefits  
18 coverage to a member of an IMA unless  
19 the same coverage is offered to all such  
20 members of the IMA.

21           “(ii) CONSTRUCTION.—Nothing in  
22 this title shall be construed as requiring or  
23 permitting a health insurance issuer to  
24 provide coverage outside the service area of  
25 the issuer, as approved under State law, or

1           requiring a health insurance issuer from  
2 excluding or limiting the coverage on any  
3 individual, subject to the requirement of  
4 section 2741.

5           “(C) NO FINANCIAL UNDERWRITING.—The  
6 IMA provides health benefits coverage only  
7 through contracts with health insurance issuers  
8 and does not assume insurance risk with re-  
9 spect to such coverage.

10           “(3) GEOGRAPHIC AREAS.—Nothing in this title  
11 shall be construed as preventing the establishment  
12 and operation of more than one IMA in a geographic  
13 area or as limiting the number of IMAs that may  
14 operate in any area.

15           “(4) PROVISION OF ADMINISTRATIVE SERVICES  
16 TO PURCHASERS.—

17           “(A) IN GENERAL.—The IMA may provide  
18 administrative services for members. Such serv-  
19 ices may include accounting, billing, and enroll-  
20 ment information.

21           “(B) CONSTRUCTION.—Nothing in this  
22 subsection shall be construed as preventing an  
23 IMA from serving as an administrative service  
24 organization to any entity.

1           “(5) FILING INFORMATION.—The IMA files  
2     with the Secretary information that demonstrates  
3     the IMA’s compliance with the applicable require-  
4     ments of this title.

5           “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
6     MENTS.—

7           “(1) COMPLIANCE WITH CONSUMER PROTEC-  
8     TION REQUIREMENTS.—Any health benefits coverage  
9     offered through an IMA shall—

10           “(A) be underwritten by a health insurance  
11     issuer that—

12           “(i) is licensed (or otherwise regu-  
13     lated) under State law,

14           “(ii) meets all applicable State stand-  
15     ards relating to consumer protection, sub-  
16     ject to section 3002(b), and

17           “(B) subject to paragraph (2), be approved  
18     or otherwise permitted to be offered under  
19     State law.

20           “(2) EXAMPLES OF TYPES OF COVERAGE.—The  
21     benefits coverage made available through an IMA  
22     may include, but is not limited to, any of the fol-  
23     lowing if it meets the other applicable requirements  
24     of this title:

1           “(A) Coverage through a health mainte-  
2     nance organization.

3           “(B) Coverage in connection with a pre-  
4     ferred provider organization.

5           “(C) Coverage in connection with a li-  
6     censed provider-sponsored organization.

7           “(D) Indemnity coverage through an insur-  
8     ance company.

9           “(E) Coverage offered in connection with a  
10     contribution into a medical savings account,  
11     health savings account, or flexible spending ac-  
12     count.

13           “(F) Coverage that includes a point-of-  
14     service option.

15           “(G) Any combination of such types of  
16     coverage.

17           “(3) WELLNESS BONUSES FOR HEALTH PRO-  
18     MOTION.—Nothing in this title shall be construed as  
19     precluding a health insurance issuer offering health  
20     benefits coverage through an IMA from establishing  
21     premium discounts or rebates for members or from  
22     modifying otherwise applicable copayments or  
23     deductibles in return for adherence to programs of  
24     health promotion and disease prevention so long as  
25     such programs are agreed to in advance by the IMA

1 and comply with all other provisions of this title and  
2 do not discriminate among similarly situated mem-  
3 bers.

4 “(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

5 “(1) MEMBERS.—

6 “(A) IN GENERAL.—Under rules estab-  
7 lished to carry out this title, with respect to an  
8 individual who is a member of an IMA, the in-  
9 dividual may enroll for health benefits coverage  
10 (including coverage for dependents of such indi-  
11 vidual) offered by a health insurance issuer  
12 through the IMA.

13 “(B) RULES FOR ENROLLMENT.—Nothing  
14 in this paragraph shall preclude an IMA from  
15 establishing rules of enrollment and reenroll-  
16 ment of members. Such rules shall be applied  
17 consistently to all members within the IMA and  
18 shall not be based in any manner on health sta-  
19 tus-related factors.

20 “(2) HEALTH INSURANCE ISSUERS.—The con-  
21 tract between an IMA and a health insurance issuer  
22 shall provide, with respect to a member enrolled with  
23 health benefits coverage offered by the issuer  
24 through the IMA, for the payment of the premiums  
25 collected by the issuer.

1 “SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-  
2 MENTS.

3 “State laws insofar as they relate to any of the fol-  
4 lowing are superseded and shall not apply to health bene-  
5 fits coverage made available through an IMA:

6 “(1) Benefit requirements for health benefits  
7 coverage offered through an IMA, including (but not  
8 limited to) requirements relating to coverage of spe-  
9 cific providers, specific services or conditions, or the  
10 amount, duration, or scope of benefits, but not in-  
11 cluding requirements to the extent required to imple-  
12 ment title XXVII or other Federal law and to the  
13 extent the requirement prohibits an exclusion of a  
14 specific disease from such coverage.

15 “(2) Any other requirements (including limita-  
16 tions on compensation arrangements) that, directly  
17 or indirectly, preclude (or have the effect of pre-  
18 cluding) the offering of such coverage through an  
19 IMA, if the IMA meets the requirements of this  
20 title.

21 Any State law or regulation relating to the composition  
22 or organization of an IMA is preempted to the extent the  
23 law or regulation is inconsistent with the provisions of this  
24 title.

1 **“SEC. 3103. ADMINISTRATION.**

2 “(a) IN GENERAL.—The Secretary shall administer  
3 this title and is authorized to issue such regulations as  
4 may be required to carry out this title. Such regulations  
5 shall be subject to Congressional review under the provi-  
6 sions of chapter 8 of title 5, United States Code. The Sec-  
7 retary shall incorporate the process of ‘deemed file and  
8 usc’ with respect to the information filed under section  
9 3001(a)(5)(A) and shall determine whether information  
10 filed by an IMA demonstrates compliance with the applica-  
11 ble requirements of this title. The Secretary shall exercise  
12 authority under this title in a manner that fosters and  
13 promotes the development of IMAs in order to improve  
14 access to health care coverage and services.

15 “(b) PERIODIC REPORTS.—The Secretary shall sub-  
16 mit to Congress a report every 30 months, during the 10-  
17 year period beginning on the effective date of the rules  
18 promulgated by the Secretary to carry out this title, on  
19 the effectiveness of this title in promoting coverage of un-  
20 insured individuals. The Secretary may provide for the  
21 production of such reports through one or more contracts  
22 with appropriate private entities.

23 **“SEC. 3104. DEFINITIONS.**

24 “For purposes of this title:

1 “(1) ASSOCIATION.—The term ‘association’  
2 means, with respect to health insurance coverage of-  
3 fered in a State, an association which—

4 “(A) has been actively in existence for at  
5 least 5 years;

6 “(B) has been formed and maintained in  
7 good faith for purposes other than obtaining in-  
8 surance;

9 “(C) does not condition membership in the  
10 association on any health status-related factor  
11 relating to an individual (including an employee  
12 of an employer or a dependent of an employee);  
13 and

14 “(D) does not make health insurance cov-  
15 erage offered through the association available  
16 other than in connection with a member of the  
17 association.

18 “(2) DEPENDENT.—The term ‘dependent’, as  
19 applied to health insurance coverage offered by a  
20 health insurance issuer licensed (or otherwise regu-  
21 lated) in a State, shall have the meaning applied to  
22 such term with respect to such coverage under the  
23 laws of the State relating to such coverage and such  
24 an issuer. Such term may include the spouse and  
25 children of the individual involved.

1           “(3) HEALTH BENEFITS COVERAGE.—The term  
2 ‘health benefits coverage’ has the meaning given the  
3 term health insurance coverage in section  
4 2791(b)(1).

5           “(4) HEALTH INSURANCE ISSUER.—The term  
6 ‘health insurance issuer’ has the meaning given such  
7 term in section 2791(b)(2).

8           “(5) HEALTH STATUS-RELATED FACTOR.—The  
9 term ‘health status-related factor’ has the meaning  
10 given such term in section 2791(d)(9).

11           “(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIA-  
12 TION.—The terms ‘IMA’ and ‘individual membership  
13 association’ are defined in section 3101(a).

14           “(7) MEMBER.—The term ‘member’ means,  
15 with respect to an IMA, an individual who is a mem-  
16 ber of the association to which the IMA is offering  
17 coverage.”

18           **Subtitle C—Association Health**  
19                           **Plans**

20           **SEC. 121. RULES GOVERNING ASSOCIATION HEALTH**  
21                           **PLANS.**

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

1           **“PART 8—RULES GOVERNING ASSOCIATION**

2                           **HEALTH PLANS**

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

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

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

10           “(1) is organized and maintained in good faith,  
11 with a constitution and bylaws specifically stating its  
12 purpose and providing for periodic meetings on at  
13 least an annual basis, as a bona fide trade associa-  
14 tion, a bona fide industry association (including a  
15 rural electric cooperative association or a rural tele-  
16 phone cooperative association), a bona fide profes-  
17 sional association, or a bona fide chamber of com-  
18 merce (or similar bona fide business association, in-  
19 cluding a corporation or similar organization that  
20 operates on a cooperative basis (within the meaning  
21 of section 1381 of the Internal Revenue Code of  
22 1986)), for substantial purposes other than that of  
23 obtaining or providing medical care;

24           “(2) is established as a permanent entity which  
25 receives the active support of its members and re-  
26 quires for membership payment on a periodic basis

1 of dues or payments necessary to maintain eligibility  
2 for membership in the sponsor; and

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

10 Any sponsor consisting of an association of entities which  
11 meet the requirements of paragraphs (1), (2), and (3)  
12 shall be deemed to be a sponsor described in this sub-  
13 section.

14 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
15 **PLANS.**

16 “(a) IN GENERAL.—The applicable authority shall  
17 prescribe by regulation a procedure under which, subject  
18 to subsection (b), the applicable authority shall certify as-  
19 sociation health plans which apply for certification as  
20 meeting the requirements of this part.

21 “(b) STANDARDS.—Under the procedure prescribed  
22 pursuant to subsection (a), in the case of an association  
23 health plan that provides at least one benefit option which  
24 does not consist of health insurance coverage, the applica-  
25 ble authority shall certify such plan as meeting the re-

1 requirements of this part only if the applicable authority is  
2 satisfied that the applicable requirements of this part are  
3 met (or, upon the date on which the plan is to commence  
4 operations, will be met) with respect to the plan.

5 “(e) REQUIREMENTS APPLICABLE TO CERTIFIED  
6 PLANS.—An association health plan with respect to which  
7 certification under this part is in effect shall meet the ap-  
8 plicable requirements of this part, effective on the date  
9 of certification (or, if later, on the date on which the plan  
10 is to commence operations).

11 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
12 CATION.—The applicable authority may provide by regula-  
13 tion for continued certification of association health plans  
14 under this part.

15 “(e) CLASS CERTIFICATION FOR FULLY INSURED  
16 PLANS.—The applicable authority shall establish a class  
17 certification procedure for association health plans under  
18 which all benefits consist of health insurance coverage.  
19 Under such procedure, the applicable authority shall pro-  
20 vide for the granting of certification under this part to  
21 the plans in each class of such association health plans  
22 upon appropriate filing under such procedure in connec-  
23 tion with plans in such class and payment of the pre-  
24 scribed fee under section 807(a).



1           “(2) RULES OF OPERATION AND FINANCIAL  
2     CONTROLS.—The board of trustees has in effect  
3     rules of operation and financial controls, based on a  
4     3-year plan of operation, adequate to carry out the  
5     terms of the plan and to meet all requirements of  
6     this title applicable to the plan.

7           “(3) RULES GOVERNING RELATIONSHIP TO  
8     PARTICIPATING EMPLOYERS AND TO CONTRAC-  
9     TORS.—

10           “(A) BOARD MEMBERSHIP.—

11           “(i) IN GENERAL.—Except as pro-  
12     vided in clauses (ii) and (iii), the members  
13     of the board of trustees are individuals se-  
14     lected from individuals who are the owners,  
15     officers, directors, or employees of the par-  
16     ticipating employers or who are partners in  
17     the participating employers and actively  
18     participate in the business.

19           “(ii) LIMITATION.—

20           “(I) GENERAL RULE.—Except as  
21     provided in subclauses (II) and (III),  
22     no such member is an owner, officer,  
23     director, or employee of, or partner in,  
24     a contract administrator or other  
25     service provider to the plan.

1           “(II) LIMITED EXCEPTION FOR  
2     PROVIDERS OF SERVICES SOLELY ON  
3     BEHALF OF THE SPONSOR.—Officers  
4     or employees of a sponsor which is a  
5     service provider (other than a contract  
6     administrator) to the plan may be  
7     members of the board if they con-  
8     stitute not more than 25 percent of  
9     the membership of the board and they  
10    do not provide services to the plan  
11    other than on behalf of the sponsor.

12           “(III) TREATMENT OF PRO-  
13     VIDERS OF MEDICAL CARE.—In the  
14     case of a sponsor which is an associa-  
15     tion whose membership consists pri-  
16     marily of providers of medical care,  
17     subclause (I) shall not apply in the  
18     case of any service provider described  
19     in subclause (I) who is a provider of  
20     medical care under the plan.

21           “(iii) CERTAIN PLANS EXCLUDED.—  
22     Clause (i) shall not apply to an association  
23     health plan which is in existence on the  
24     date of the enactment of the Small Busi-  
25     ness Health Fairness Act of 2009.



1 employees of, or partners in, participating em-  
2 ployers; or

3 “(B) the beneficiaries of individuals de-  
4 scribed in subparagraph (A).

5 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
6 PLOYEES.—In the case of an association health plan in  
7 existence on the date of the enactment of the Small Busi-  
8 ness Health Fairness Act of 2009, an affiliated member  
9 of the sponsor of the plan may be offered coverage under  
10 the plan as a participating employer only if—

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

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

20 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
21 quirements of this subsection are met with respect to an  
22 association health plan if, under the terms of the plan,  
23 no participating employer may provide health insurance  
24 coverage in the individual market for any employee not  
25 covered under the plan which is similar to the coverage

1 contemporaneously provided to employees of the employer  
2 under the plan, if such exclusion of the employee from cov-  
3 erage under the plan is based on a health status-related  
4 factor with respect to the employee and such employee  
5 would, but for such exclusion on such basis, be eligible  
6 for coverage under the plan.

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

11 “(1) under the terms of the plan, all employers  
12 meeting the preceding requirements of this section  
13 are eligible to qualify as participating employers for  
14 all geographically available coverage options, unless,  
15 in the case of any such employer, participation or  
16 contribution requirements of the type referred to in  
17 section 2711 of the Public Health Service Act (42  
18 U.S.C. 300gg-11) are not met;

19 “(2) upon request, any employer eligible to partici-  
20 pitate is furnished information regarding all cov-  
21 erage options available under the plan; and

22 “(3) the applicable requirements of sections  
23 701, 702, and 703 are met with respect to the plan.

1 **"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
 2 **DOCUMENTS, CONTRIBUTION RATES, AND**  
 3 **BENEFIT OPTIONS.**

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

7 "(1) CONTENTS OF GOVERNING INSTRU-  
 8 MENTS.—The instruments governing the plan in-  
 9 clude a written instrument, meeting the require-  
 10 ments of an instrument required under section  
 11 402(a)(1), which—

12 "(A) provides that the board of trustees  
 13 serves as the named fiduciary required for plans  
 14 under section 402(a)(1) and serves in the ca-  
 15 pacity of a plan administrator (referred to in  
 16 section 3(16)(A));

17 "(B) provides that the sponsor of the plan  
 18 is to serve as plan sponsor (referred to in sec-  
 19 tion 3(16)(B)); and

20 "(C) incorporates the requirements of sec-  
 21 tion 806.

22 "(2) CONTRIBUTION RATES MUST BE NON-  
 23 DISCRIMINATORY.—

24 "(A) The contribution rates for any par-  
 25 ticipating small employer do not vary on the  
 26 basis of any health status-related factor in rela-

1 tion to employees of such employer or their  
 2 beneficiaries and do not vary on the basis of the  
 3 type of business or industry in which such em-  
 4 ployer is engaged.

5 "(B) Nothing in this title or any other pro-  
 6 vision of law shall be construed to preclude an  
 7 association health plan, or a health insurance  
 8 issuer offering health insurance coverage in  
 9 connection with an association health plan,  
 10 from—

11 "(i) setting contribution rates based  
 12 on the claims experience of the plan; or

13 "(ii) varying contribution rates for  
 14 small employers in a State to the extent  
 15 that such rates could vary using the same  
 16 methodology employed in such State for  
 17 regulating premium rates in the small  
 18 group market with respect to health insur-  
 19 ance coverage offered in connection with  
 20 bona fide associations (within the meaning  
 21 of section 2791(d)(3) of the Public Health  
 22 Service Act (42 U.S.C. 300gg-91(d)(3)),  
 23 subject to the requirements of section 702(b)  
 24 relating to contribution rates.

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

7           “(4) MARKETING REQUIREMENTS.—

8           “(A) IN GENERAL.—If a benefit option  
9     which consists of health insurance coverage is  
10    offered under the plan, State-licensed insurance  
11    agents shall be used to distribute to small em-  
12    ployers coverage which does not consist of  
13    health insurance coverage in a manner com-  
14    parable to the manner in which such agents are  
15    used to distribute health insurance coverage.

16          “(B) STATE-LICENSED INSURANCE  
17    AGENTS.—For purposes of subparagraph (A),  
18    the term ‘State-licensed insurance agents’  
19    means one or more agents who are licensed in  
20    a State and are subject to the laws of such  
21    State relating to licensure, qualification, test-  
22    ing, examination, and continuing education of  
23    persons authorized to offer, sell, or solicit  
24    health insurance coverage in such State.

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

6           “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
7    DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
8    nothing in this part or any provision of State law (as de-  
9    fined in section 514(e)(1)) shall be construed to preclude  
10   an association health plan, or a health insurance issuer  
11   offering health insurance coverage in connection with an  
12   association health plan, from exercising its sole discretion  
13   in selecting the specific items and services consisting of  
14   medical care to be included as benefits under such plan  
15   or coverage, except (subject to section 514) in the case  
16   of (1) any law to the extent that it is not preempted under  
17   section 731(a)(1) with respect to matters governed by sec-  
18   tion 711, 712, or 713, or (2) any law of the State with  
19   which filing and approval of a policy type offered by the  
20   plan was initially obtained to the extent that such law pro-  
21   hibits an exclusion of a specific disease from such cov-  
22   erage.

1 **"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
 2 **FOR SOLVENCY FOR PLANS PROVIDING**  
 3 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
 4 **INSURANCE COVERAGE.**

5 "(a) IN GENERAL.—The requirements of this section  
 6 are met with respect to an association health plan if—

7 "(1) the benefits under the plan consist solely  
 8 of health insurance coverage; or

9 "(2) if the plan provides any additional benefit  
 10 options which do not consist of health insurance cov-  
 11 erage, the plan—

12 "(A) establishes and maintains reserves  
 13 with respect to such additional benefit options,  
 14 in amounts recommended by the qualified actu-  
 15 ary, consisting of—

16 "(i) a reserve sufficient for unearned  
 17 contributions;

18 "(ii) a reserve sufficient for benefit li-  
 19 abilities which have been incurred, which  
 20 have not been satisfied, and for which risk  
 21 of loss has not yet been transferred, and  
 22 for expected administrative costs with re-  
 23 spect to such benefit liabilities;

24 "(iii) a reserve sufficient for any other  
 25 obligations of the plan; and

1 "(iv) a reserve sufficient for a margin  
 2 of error and other fluctuations, taking into  
 3 account the specific circumstances of the  
 4 plan; and

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

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

21 "(ii) The plan shall secure specific ex-  
 22 cess/stop loss insurance for the plan with  
 23 an attachment point which is at least equal  
 24 to an amount recommended by the plan's  
 25 qualified actuary. The applicable authority

1 may by regulation provide for adjustments  
2 in the amount of such insurance in speci-  
3 fied circumstances in which the plan spe-  
4 cifically provides for and maintains re-  
5 serves in excess of the amounts required  
6 under subparagraph (A).

7 “(iii) The plan shall secure indem-  
8 nification insurance for any claims which  
9 the plan is unable to satisfy by reason of  
10 a plan termination.

11 Any person issuing to a plan insurance described in clause  
12 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
13 retary of any failure of premium payment meriting can-  
14 cellation of the policy prior to undertaking such a cancella-  
15 tion. Any regulations prescribed by the applicable author-  
16 ity pursuant to clause (i) or (ii) of subparagraph (B) may  
17 allow for such adjustments in the required levels of excess/  
18 stop loss insurance as the qualified actuary may rec-  
19 ommend, taking into account the specific circumstances  
20 of the plan.

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

1 “(1) \$500,000, or

2 “(2) such greater amount (but not greater than  
3 \$2,000,000) as may be set forth in regulations pre-  
4 scribed by the applicable authority, considering the  
5 level of aggregate and specific excess/stop loss insur-  
6 ance provided with respect to such plan and other  
7 factors related to solvency risk, such as the plan’s  
8 projected levels of participation or claims, the nature  
9 of the plan’s liabilities, and the types of assets avail-  
10 able to assure that such liabilities are met.

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

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

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

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

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

24               “(A) IN GENERAL.—In the case of an as-  
 25 sociation health plan described in subsection

1       (a)(2), the requirements of this subsection are  
 2 met if the plan makes payments into the Asso-  
 3 ciation Health Plan Fund under this subpara-  
 4 graph when they are due. Such payments shall  
 5 consist of annual payments in the amount of  
 6 \$5,000, and, in addition to such annual pay-  
 7 ments, such supplemental payments as the Sec-  
 8 retary may determine to be necessary under  
 9 paragraph (2). Payments under this paragraph  
 10 are payable to the Fund at the time determined  
 11 by the Secretary. Initial payments are due in  
 12 advance of certification under this part. Pay-  
 13 ments shall continue to accrue until a plan's as-  
 14 sets are distributed pursuant to a termination  
 15 procedure.

16               “(B) PENALTIES FOR FAILURE TO MAKE  
 17 PAYMENTS.—If any payment is not made by a  
 18 plan when it is due, a late payment charge of  
 19 not more than 100 percent of the payment  
 20 which was not timely paid shall be payable by  
 21 the plan to the Fund.

22               “(C) CONTINUED DUTY OF THE SEC-  
 23 RETARY.—The Secretary shall not cease to  
 24 carry out the provisions of paragraph (2) on ac-

1 count of the failure of a plan to pay any pay-  
2 ment when due.

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

1 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

7           “(B) which is guaranteed renewable; and

8           “(C) which allows for payment of pre-  
9           miums by any third party on behalf of the in-  
10          sured plan.

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

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

23               “(B) which is guaranteed renewable; and

1           “(C) which allows for payment of pre-  
2           miums by any third party on behalf of the in-  
3           sured plan.

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

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

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

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

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

1 “(j) SOLVENCY STANDARDS WORKING GROUP.—

2 “(1) IN GENERAL.—Within 90 days after the  
3 date of the enactment of the Small Business Health  
4 Fairness Act of 2009, the applicable authority shall  
5 establish a Solvency Standards Working Group. In  
6 prescribing the initial regulations under this section,  
7 the applicable authority shall take into account the  
8 recommendations of such Working Group.

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

15 “(A) A representative of the National As-  
16 sociation of Insurance Commissioners.

17 “(B) A representative of the American  
18 Academy of Actuaries.

19 “(C) A representative of the State govern-  
20 ments, or their interests.

21 “(D) A representative of existing self-in-  
22 sured arrangements, or their interests.

23 “(E) A representative of associations of  
24 the type referred to in section 801(b)(1), or  
25 their interests.

1 “(F) A representative of multiemployer  
2 plans that are group health plans, or their in-  
3 terests.

4 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-  
5 LATED REQUIREMENTS.**

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

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

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

23 “(A) the sponsor; and

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

1           “(2) STATES IN WHICH PLAN INTENDS TO DO  
2 BUSINESS.—The States in which participants and  
3 beneficiaries under the plan are to be located and  
4 the number of them expected to be located in each  
5 such State.

6           “(3) BONDING REQUIREMENTS.—Evidence pro-  
7 vided by the board of trustees that the bonding re-  
8 quirements of section 412 will be met as of the date  
9 of the application or (if later) commencement of op-  
10 erations.

11           “(4) PLAN DOCUMENTS.—A copy of the docu-  
12 ments governing the plan (including any bylaws and  
13 trust agreements), the summary plan description,  
14 and other material describing the benefits that will  
15 be provided to participants and beneficiaries under  
16 the plan.

17           “(5) AGREEMENTS WITH SERVICE PRO-  
18 VIDERS.—A copy of any agreements between the  
19 plan and contract administrators and other service  
20 providers.

21           “(6) FUNDING REPORT.—In the case of asso-  
22 ciation health plans providing benefits options in ad-  
23 dition to health insurance coverage, a report setting  
24 forth information with respect to such additional  
25 benefit options determined as of a date within the

1 120-day period ending with the date of the applica-  
2 tion, including the following:

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

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

24           “(C) CURRENT AND PROJECTED VALUE OF  
25 ASSETS AND LIABILITIES.—A statement of ac-

1 tuarial opinion signed by a qualified actuary,  
2 which sets forth the current value of the assets  
3 and liabilities accumulated under the plan and  
4 a projection of the assets, liabilities, income,  
5 and expenses of the plan for the 12-month pe-  
6 riod referred to in subparagraph (B). The in-  
7 come statement shall identify separately the  
8 plan's administrative expenses and claims.

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

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

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

1 shall be considered to be located in the State in which a  
2 known address of such individual is located or in which  
3 such individual is employed.

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

14 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
15 SOCIATION HEALTH PLANS.—An association health plan  
16 certified under this part which provides benefit options in  
17 addition to health insurance coverage for such plan year  
18 shall meet the requirements of section 103 by filing an  
19 annual report under such section which shall include infor-  
20 mation described in subsection (b)(6) with respect to the  
21 plan year and, notwithstanding section 104(a)(1)(A), shall  
22 be filed with the applicable authority not later than 90  
23 days after the close of the plan year (or on such later date  
24 as may be prescribed by the applicable authority). The ap-

1 plicable authority may require by regulation such interim  
2 reports as it considers appropriate.

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

16 “(1) are in the aggregate reasonably related to  
17 the experience of the plan and to reasonable expecta-  
18 tions; and

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

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

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
2 **MINATION.**

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

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

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

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

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

22 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
23 **NATION.**

24 “(a) ACTIONS TO AVOID DEPLETION OF RE-  
25 SERVES.—An association health plan which is certified  
26 under this part and which provides benefits other than

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

1 “(b) MANDATORY TERMINATION.—In any case in  
2 which—  
3 “(1) the applicable authority has been notified  
4 under subsection (a) (or by an issuer of excess/stop  
5 loss insurance or indemnity insurance pursuant to  
6 section 806(a)) of a failure of an association health  
7 plan which is or has been certified under this part  
8 and is described in section 806(a)(2) to meet the re-  
9 quirements of section 806 and has not been notified  
10 by the board of trustees of the plan that corrective  
11 action has restored compliance with such require-  
12 ments; and  
13 “(2) the applicable authority determines that  
14 there is a reasonable expectation that the plan will  
15 continue to fail to meet the requirements of section  
16 806,  
17 the board of trustees of the plan shall, at the direction  
18 of the applicable authority, terminate the plan and, in the  
19 course of the termination, take such actions as the appli-  
20 cable authority may require, including satisfying any  
21 claims referred to in section 806(a)(2)(B)(iii) and recov-  
22 ering for the plan any liability under subsection  
23 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
24 that the affairs of the plan will be, to the maximum extent

1 possible, wound up in a manner which will result in timely  
2 provision of all benefits for which the plan is obligated.

3 **"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
4 **VENT ASSOCIATION HEALTH PLANS PRO-**  
5 **VIDING HEALTH BENEFITS IN ADDITION TO**  
6 **HEALTH INSURANCE COVERAGE.**

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

1 tence of this subsection are remedied or the plan is termi-  
2 nated.

3 **"(b) POWERS AS TRUSTEE.**—The Secretary, upon  
4 appointment as trustee under subsection (a), shall have  
5 the power—

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

9 **"(2)** to require the transfer of all (or any part)  
10 of the assets and records of the plan to the Sec-  
11 retary as trustee;

12 **"(3)** to invest any assets of the plan which the  
13 Secretary holds in accordance with the provisions of  
14 the plan, regulations prescribed by the Secretary,  
15 and applicable provisions of law;

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

22 **"(5)** to collect for the plan any amounts due the  
23 plan and to recover reasonable expenses of the trust-  
24 ecship;

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

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

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

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

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

21 “(e) NOTICE OF APPOINTMENT.—As soon as prac-  
22 ticable after the Secretary’s appointment as trustee, the  
23 Secretary shall give notice of such appointment to—

24 “(1) the sponsor and plan administrator;

25 “(2) each participant;

1 “(3) each participating employer; and

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

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

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

19 “(f) JURISDICTION OF COURT.—

20 “(1) IN GENERAL.—Upon the filing of an appli-  
21 cation for the appointment as trustee or the issuance  
22 of a decree under this section, the court to which the  
23 application is made shall have exclusive jurisdiction  
24 of the plan involved and its property wherever lo-  
25 cated with the powers, to the extent consistent with

1 the purposes of this section, of a court of the United  
2 States having jurisdiction over cases under chapter  
3 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and  
4 upon appointment by it of the Secretary as trustee,  
5 such court shall continue the stay of, any pending  
6 mortgage foreclosure, equity receivership, or other  
7 proceeding to reorganize, conserve, or liquidate the  
8 plan, the sponsor, or property of such plan or sponsor,  
9 and any other suit against any receiver, conservator,  
10 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  
11 to enforce a lien against property of the plan or the  
12 sponsor or any other suit against the plan or the  
13 sponsor.

14       “(2) VENUE.—An action under this section  
15 may be brought in the judicial district where the  
16 sponsor or the plan administrator resides or does  
17 business or where any asset of the plan is situated.  
18 A district court in which such action is brought may  
19 issue process with respect to such action in any  
20 other judicial district.  
21  
22  
23  
24

1       “(g) PERSONNEL.—In accordance with regulations  
2 which shall be prescribed by the Secretary, the Secretary  
3 shall appoint, retain, and compensate accountants, actuaries,  
4 and other professional service personnel as may be  
5 necessary in connection with the Secretary’s service as  
6 trustee under this section.

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

8       “(a) IN GENERAL.—Notwithstanding section 514, a  
9 State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan  
10 commenced operations in such State after the date of the  
11 enactment of the Small Business Health Fairness Act of  
12 2009.  
13

14       “(b) CONTRIBUTION TAX.—For purposes of this section, the term ‘contribution tax’ imposed by a State on  
15 an association health plan means any tax imposed by such  
16 State if—  
17

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

23       “(2) the rate of such tax does not exceed the  
24 rate of any tax imposed by such State on premiums  
25

1 or contributions received by insurers or health main-  
 2 tenance organizations for health insurance coverage  
 3 offered in such State in connection with a group  
 4 health plan;

5 “(3) such tax is otherwise nondiscriminatory;  
 6 and

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

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

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

21 “(1) GROUP HEALTH PLAN.—The term ‘group  
 22 health plan’ has the meaning provided in section  
 23 733(a)(1) (after applying subsection (b) of this sec-  
 24 tion).

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

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

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

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

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

19 “(7) INDIVIDUAL MARKET.—

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

24 “(B) TREATMENT OF VERY SMALL  
 25 GROUPS.—

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

8           “(ii) STATE EXCEPTION.—Clause (i)  
9           shall not apply in the case of health insur-  
10          ance coverage offered in a State if such  
11          State regulates the coverage described in  
12          such clause in the same manner and to the  
13          same extent as coverage in the small group  
14          market (as defined in section 2791(e)(5) of  
15          the Public Health Service Act (42 U.S.C.  
16          300gg–91(e)(5)) is regulated by such  
17          State.

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

1           the status of such individual as such an employee,  
2           partner, or self-employed individual in relation to the  
3           plan.

4           “(9) APPLICABLE STATE AUTHORITY.—The  
5           term ‘applicable State authority’ means, with respect  
6           to a health insurance issuer in a State, the State in-  
7           surance commissioner or official or officials des-  
8           ignated by the State to enforce the requirements of  
9           title XXVII of the Public Health Service Act (42  
10          U.S.C. 300hh et seq.) for the State involved with re-  
11          spect to such issuer.

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

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

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

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

24                  “(C) in the case of an association health  
25                  plan in existence on the date of the enactment

1 of the Small Business Health Fairness Act of  
2 2009, a person eligible to be a member of the  
3 sponsor or one of its member associations.

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

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

15 “(b) RULES OF CONSTRUCTION.—

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

23 “(A) in the case of a partnership, the term  
24 ‘employer’ (as defined in section 3(5)) includes  
25 the partnership in relation to the partners, and

1 the term ‘employee’ (as defined in section 3(6))  
2 includes any partner in relation to the partner-  
3 ship; and

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

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

22 (b) CONFORMING AMENDMENTS TO PREEMPTION  
23 RULES.—

1 (1) Section 514(b)(6) of such Act (29 U.S.C.  
2 1144(b)(6)) is amended by adding at the end the  
3 following new subparagraph:

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

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

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

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

20 (C) by redesignating subsection (d) as sub-  
21 section (e); and

22 (D) by inserting after subsection (c) the  
23 following new subsection:

24 “(d)(1) Except as provided in subsection (b)(4), the  
25 provisions of this title shall supersede any and all State

1 laws insofar as they may now or hereafter preclude, or  
2 have the effect of precluding, a health insurance issuer  
3 from offering health insurance coverage in connection with  
4 an association health plan which is certified under part  
5 8.

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

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

20 “(B) In any case in which health insurance cov-  
21 erage of any policy type is offered in a State under  
22 an association health plan certified under part 8 and  
23 the filing, with the applicable State authority (as de-  
24 fined in section 812(a)(9)), of the policy form in  
25 connection with such policy type is approved by such

1 State authority, the provisions of this title shall sup-  
 2 persede any and all laws of any other State in which  
 3 health insurance coverage of such type is offered, in-  
 4 sofar as they may preclude, upon the filing in the  
 5 same form and manner of such policy form with the  
 6 applicable State authority in such other State, the  
 7 approval of the filing in such other State.

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

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

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

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

19 “(5) For purposes of this subsection, the term ‘asso-  
 20 ciation health plan’ has the meaning provided in section  
 21 801(a), and the terms ‘health insurance coverage’, ‘par-  
 22 ticipating employer’, and ‘health insurance issuer’ have  
 23 the meanings provided such terms in section 812, respec-  
 24 tively.”.

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

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

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

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

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

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

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

23 (B) by adding at the end the following new  
 24 paragraph:

1 “(2) Nothing in any other provision of law enacted  
2 on or after the date of the enactment of the Small Busi-  
3 ness Health Fairness Act of 2009 shall be construed to  
4 alter, amend, modify, invalidate, impair, or supersede any  
5 provision of this title, except by specific cross-reference to  
6 the affected section.”.

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

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

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

23 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
24 CATION OF SELF-INSURED ASSOCIATION HEALTH  
25 PLANS.—Not later than January 1, 2012, the Secretary

1 of Labor shall report to the Committee on Education and  
2 the Workforce of the House of Representatives and the  
3 Committee on Health, Education, Labor, and Pensions of  
4 the Senate the effect association health plans have had,  
5 if any, on reducing the number of uninsured individuals.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

10 **SEC. 122. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
11 **PLOYER ARRANGEMENTS.**

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

15 (1) in clause (i), by inserting after “control  
16 group,” the following: “except that, in any case in  
17 which the benefit referred to in subparagraph (A)

1 consists of medical care (as defined in section  
2 812(a)(2)), two or more trades or businesses, wheth-  
3 er or not incorporated, shall be deemed a single em-  
4 ployer for any plan year of such plan, or any fiscal  
5 year of such other arrangement, if such trades or  
6 businesses are within the same control group during  
7 such year or at any time during the preceding 1-year  
8 period.”;

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

11 “(iii)(I) in any case in which the benefit re-  
12 ferred to in subparagraph (A) consists of medical  
13 care (as defined in section 812(a)(2)), the deter-  
14 mination of whether a trade or business is under  
15 ‘common control’ with another trade or business  
16 shall be determined under regulations of the Sec-  
17 retary applying principles consistent and coextensive  
18 with the principles applied in determining whether  
19 employees of two or more trades or businesses are  
20 treated as employed by a single employer under sec-  
21 tion 4001(b), except that, for purposes of this para-  
22 graph, an interest of greater than 25 percent may  
23 not be required as the minimum interest necessary  
24 for common control, or

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

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

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

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

19 **SEC. 123. ENFORCEMENT PROVISIONS RELATING TO ASSO-  
20 CIATION HEALTH PLANS.**

21 (a) **CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
22 MISREPRESENTATIONS.**—Section 501 of the Employee  
23 Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
24 is amended—

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

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

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

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

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

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

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

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

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

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

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

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

5           “(A) all benefits under it referred to in  
6 paragraph (1) consist of health insurance cov-  
7 erage; and

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

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

19           “(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—

20 Section 503 of such Act (29 U.S.C. 1133) is amended by  
21 inserting “(a) IN GENERAL.—” before “In accordance”,  
22 and by adding at the end the following new subsection:

23           “(b) ASSOCIATION HEALTH PLANS.—The terms of  
24 each association health plan which is or has been certified  
25 under part 8 shall require the board of trustees or the

1 named fiduciary (as applicable) to ensure that the require-  
2 ments of this section are met in connection with claims  
3 filed under the plan.”.

4 **SEC. 124. COOPERATION BETWEEN FEDERAL AND STATE**

5 **AUTHORITIES.**

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

9           “(d) CONSULTATION WITH STATES WITH RESPECT  
10 TO ASSOCIATION HEALTH PLANS.—

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

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

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

22           “(2) RECOGNITION OF PRIMARY DOMICILE  
23 STATE.—In carrying out paragraph (1), the Sec-  
24 retary shall ensure that only one State will be recog-  
25 nized, with respect to any particular association

1 health plan, as the State with which consultation is  
2 required. In carrying out this paragraph—

3 “(A) in the case of a plan which provides  
4 health insurance coverage (as defined in section  
5 812(a)(3)), such State shall be the State with  
6 which filing and approval of a policy type of-  
7 ferred by the plan was initially obtained, and

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

13 **SEC. 125. EFFECTIVE DATE AND TRANSITIONAL AND**  
14 **OTHER RULES.**

15 (a) **EFFECTIVE DATE.**—The amendments made by  
16 this subtitle shall take effect 1 year after the date of the  
17 enactment of this Act. The Secretary of Labor shall first  
18 issue all regulations necessary to carry out the amend-  
19 ments made by this subtitle within 1 year after the date  
20 of the enactment of this Act.

21 (b) **TREATMENT OF CERTAIN EXISTING HEALTH**  
22 **BENEFITS PROGRAMS.**—

23 (1) **IN GENERAL.**—In any case in which, as of  
24 the date of the enactment of this Act, an arrange-  
25 ment is maintained in a State for the purpose of

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

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

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

22 (C) the requirements of section 803(b) of  
23 such Act shall be deemed met, if the arrange-  
24 ment is operated by a board of directors  
25 which—

1 (i) is elected by the participating em-  
 2 ployers, with each employer having one  
 3 vote; and

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

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

10 (E) the arrangement may be certified by  
 11 any applicable authority with respect to its op-  
 12 erations in any State only if it operates in such  
 13 State on the date of certification.

14 The provisions of this subsection shall cease to apply  
 15 with respect to any such arrangement at such time  
 16 after the date of the enactment of this Act as the  
 17 applicable requirements of this subsection are not  
 18 met with respect to such arrangement.

19 (2) DEFINITIONS.—For purposes of this sub-  
 20 section, the terms “group health plan”, “medical  
 21 care”, and “participating employer” shall have the  
 22 meanings provided in section 812 of the Employee  
 23 Retirement Income Security Act of 1974, except  
 24 that the reference in paragraph (7) of such section  
 25 to an “association health plan” shall be deemed a

1 reference to an arrangement referred to in this sub-  
 2 section.

3 **Subtitle D—Purchasing Insurance**  
 4 **Across State Lines**

5 **SEC. 131. COOPERATIVE GOVERNING OF INDIVIDUAL**  
 6 **HEALTH INSURANCE COVERAGE.**

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

10 **“PART D—COOPERATIVE GOVERNING OF**  
 11 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

12 **“SEC. 2795. DEFINITIONS.**

13 “In this part:

14 “(1) PRIMARY STATE.—The term ‘primary  
 15 State’ means, with respect to individual health insur-  
 16 ance coverage offered by a health insurance issuer,  
 17 the State designated by the issuer as the State  
 18 whose covered laws shall govern the health insurance  
 19 issuer in the sale of such coverage under this part.  
 20 An issuer, with respect to a particular policy, may  
 21 only designate one such State as its primary State  
 22 with respect to all such coverage it offers. Such an  
 23 issuer may not change the designated primary State  
 24 with respect to individual health insurance coverage  
 25 once the policy is issued, except that such a change

1 may be made upon renewal of the policy. With re-  
 2 spect to such designated State, the issuer is deemed  
 3 to be doing business in that State.

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

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

18 “(4) INDIVIDUAL HEALTH INSURANCE COV-  
 19 ERAGE.—The term ‘individual health insurance cov-  
 20 erage’ means health insurance coverage offered in  
 21 the individual market, as defined in section  
 22 2791(e)(1).

23 “(5) APPLICABLE STATE AUTHORITY.—The  
 24 term ‘applicable State authority’ means, with respect  
 25 to a health insurance issuer in a State, the State in-

1 surance commissioner or official or officials des-  
 2 ignated by the State to enforce the requirements of  
 3 this title for the State with respect to the issuer.

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

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

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

14 “(7) COVERED LAWS.—

15 “(A) IN GENERAL.—The term ‘covered  
 16 laws’ means the laws, rules, regulations, agree-  
 17 ments, and orders governing the insurance busi-  
 18 ness pertaining to—

19 “(i) individual health insurance cov-  
 20 erage issued by a health insurance issuer;

21 “(ii) the offer, sale, rating (including  
 22 medical underwriting), renewal, and  
 23 issuance of individual health insurance cov-  
 24 erage to an individual;

1           “(iii) the provision to an individual in  
2 relation to individual health insurance cov-  
3 erage of health care and insurance related  
4 services;

5           “(iv) the provision to an individual in  
6 relation to individual health insurance cov-  
7 erage of management, operations, and in-  
8 vestment activities of a health insurance  
9 issuer; and

10          “(v) the provision to an individual in  
11 relation to individual health insurance cov-  
12 erage of loss control and claims adminis-  
13 tration for a health insurance issuer with  
14 respect to liability for which the issuer pro-  
15 vides insurance.

16          “(B) EXCEPTION.—Such term does not in-  
17 clude any law, rule, regulation, agreement, or  
18 order governing the use of care or cost manage-  
19 ment techniques, including any requirement re-  
20 lated to provider contracting, network access or  
21 adequacy, health care data collection, or quality  
22 assurance.

23          “(8) STATE.—The term ‘State’ means the 50  
24 States and includes the District of Columbia, Puerto

1 Rico, the Virgin Islands, Guam, American Samoa,  
2 and the Northern Mariana Islands.

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

6           “(A) Knowingly misrepresenting to claim-  
7 ants and insured individuals relevant facts or  
8 policy provisions relating to coverage at issue.

9           “(B) Failing to acknowledge with reason-  
10 able promptness pertinent communications with  
11 respect to claims arising under policies.

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

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

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

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

24          “(G) A pattern or practice of compelling  
25 insured individuals or their beneficiaries to in-

1           stitute suits to recover amounts due under its  
2           policies by offering substantially less than the  
3           amounts ultimately recovered in suits brought  
4           by them.

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

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

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

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

23          “(10) FRAUD AND ABUSE.—The term ‘fraud  
24          and abuse’ means an act or omission committed by  
25          a person who, knowingly and with intent to defraud,

1           commits, or conceals any material information con-  
2           cerning, one or more of the following:

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

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

12          “(ii) The rating of an insurance policy  
13          or reinsurance contract.

14          “(iii) A claim for payment or benefit  
15          pursuant to an insurance policy or reinsur-  
16          ance contract.

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

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

22          “(vi) A document filed with the com-  
23          missioner or the chief insurance regulatory  
24          official of another jurisdiction.

1           “(vii) The financial condition of an in-  
2           surer or reinsurer.

3           “(viii) The formation, acquisition,  
4           merger, reconsolidation, dissolution or  
5           withdrawal from one or more lines of in-  
6           surance or reinsurance in all or part of a  
7           State by an insurer or reinsurer.

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

10          “(x) The reinstatement of an insur-  
11          ance policy.

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

19          “(C) Transaction of the business of insur-  
20          ance in violation of laws requiring a license, cer-  
21          tificate of authority or other legal authority for  
22          the transaction of the business of insurance.

23          “(D) Attempt to commit, aiding or abet-  
24          ting in the commission of, or conspiracy to com-

1           mit the acts or omissions specified in this para-  
2           graph.

3           **“SEC. 2796. APPLICATION OF LAW.**

4           “(a) IN GENERAL.—The covered laws of the primary  
5           State shall apply to individual health insurance coverage  
6           offered by a health insurance issuer in the primary State  
7           and in any secondary State, but only if the coverage and  
8           issuer comply with the conditions of this section with re-  
9           spect to the offering of coverage in any secondary State.

10          “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
11          ONDARY STATE.—Except as provided in this section, a  
12          health insurance issuer with respect to its offer, sale, rat-  
13          ing (including medical underwriting), renewal, and  
14          issuance of individual health insurance coverage in any  
15          secondary State is exempt from any covered laws of the  
16          secondary State (and any rules, regulations, agreements,  
17          or orders sought or issued by such State under or related  
18          to such covered laws) to the extent that such laws would—

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

23                          “(A) to pay, on a nondiscriminatory basis,  
24                          applicable premium and other taxes (including  
25                          high risk pool assessments) which are levied on

1 insurers and surplus lines insurers, brokers, or  
2 policyholders under the laws of the State;

3 “(B) to register with and designate the  
4 State insurance commissioner as its agent solely  
5 for the purpose of receiving service of legal doc-  
6 uments or process;

7 “(C) to submit to an examination of its fi-  
8 nancial condition by the State insurance com-  
9 missioner in any State in which the issuer is  
10 doing business to determine the issuer’s finan-  
11 cial condition, if—

12 “(i) the State insurance commissioner  
13 of the primary State has not done an ex-  
14 amination within the period recommended  
15 by the National Association of Insurance  
16 Commissioners; and

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

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

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

5 or

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

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

13 “(F) to participate, on a nondiscriminatory  
14 basis, in any insurance insolvency guaranty as-  
15 sociation or similar association to which a  
16 health insurance issuer in the State is required  
17 to belong;

18 “(G) to comply with any State law regard-  
19 ing fraud and abuse (as defined in section  
20 2795(10)), except that if the State seeks an in-  
21 junction regarding the conduct described in this  
22 subparagraph, such injunction must be obtained  
23 from a court of competent jurisdiction;

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

4 “(I) to comply with the applicable require-  
5 ments for independent review under section  
6 2798 with respect to coverage offered in the  
7 State;

8 “(2) require any individual health insurance  
9 coverage issued by the issuer to be countersigned by  
10 an insurance agent or broker residing in that Sec-  
11 ondary State; or

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

15 “(e) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
16 health insurance issuer shall provide the following notice,  
17 in 12-point bold type, in any insurance coverage offered  
18 in a secondary State under this part by such a health in-  
19 surance issuer and at renewal of the policy, with the 5  
20 blank spaces therein being appropriately filled with the  
21 name of the health insurance issuer, the name of primary  
22 State, the name of the secondary State, the name of the  
23 secondary State, and the name of the secondary State, re-  
24 spectively, for the coverage concerned:

1 **Notice This policy is issued by \_\_\_\_\_ and is**  
2 **governed by the laws and regulations of the**  
3 **State of \_\_\_\_\_, and it has met all the laws of**  
4 **that State as determined by that State’s De-**  
5 **partment of Insurance. This policy may be**  
6 **less expensive than others because it is not**  
7 **subject to all of the insurance laws and regu-**  
8 **lations of the State of \_\_\_\_\_, including cov-**  
9 **erage of some services or benefits mandated**  
10 **by the law of the State of \_\_\_\_\_ . Additionally,**  
11 **this policy is not subject to all of the con-**  
12 **sumer protection laws or restrictions on rate**  
13 **changes of the State of \_\_\_\_\_ . As with all in-**  
14 **surance products, before purchasing this pol-**  
15 **icy, you should carefully review the policy**  
16 **and determine what health care services the**  
17 **policy covers and what benefits it provides,**  
18 **including any exclusions, limitations, or con-**  
19 **ditions for such services or benefits.’”**

20 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
21 AND PREMIUM INCREASES.—

22 “(1) IN GENERAL.—For purposes of this sec-  
23 tion, a health insurance issuer that provides indi-  
24 vidual health insurance coverage to an individual

1 under this part in a primary or secondary State may  
2 not upon renewal—

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

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

13 “(2) CONSTRUCTION.—Nothing in paragraph  
14 (1) shall be construed to prohibit a health insurance  
15 issuer—

16 “(A) from terminating or discontinuing  
17 coverage or a class of coverage in accordance  
18 with subsections (b) and (c) of section 2742;

19 “(B) from raising premium rates for all  
20 policy holders within a class based on claims ex-  
21 perience;

22 “(C) from changing premiums or offering  
23 discounted premiums to individuals who engage  
24 in wellness activities at intervals prescribed by

1 the issuer, if such premium changes or incen-  
2 tives—

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

5 “(ii) are based on specific wellness ac-  
6 tivities that are not applicable to all indi-  
7 viduals; and

8 “(iii) are not obtainable by all individ-  
9 uals to whom coverage is offered;

10 “(D) from reinstating lapsed coverage; or

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

15 “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
16 STATE.—A health insurance issuer may not offer for sale  
17 individual health insurance coverage in a secondary State  
18 unless that coverage is currently offered for sale in the  
19 primary State.

20 “(f) LICENSING OF AGENTS OR BROKERS FOR  
21 HEALTH INSURANCE ISSUERS.—Any State may require  
22 that a person acting, or offering to act, as an agent or  
23 broker for a health insurance issuer with respect to the  
24 offering of individual health insurance coverage obtain a  
25 license from that State, with commissions or other com-

1 pension subject to the provisions of the laws of that  
2 State, except that a State may not impose any qualifica-  
3 tion or requirement which discriminates against a non-  
4 resident agent or broker.

5 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
6 SURANCE COMMISSIONER.—Each health insurance issuer  
7 issuing individual health insurance coverage in both pri-  
8 mary and secondary States shall submit—

9 “(1) to the insurance commissioner of each  
10 State in which it intends to offer such coverage, be-  
11 fore it may offer individual health insurance cov-  
12 erage in such State—

13 “(A) a copy of the plan of operation or fea-  
14 sibility study or any similar statement of the  
15 policy being offered and its coverage (which  
16 shall include the name of its primary State and  
17 its principal place of business);

18 “(B) written notice of any change in its  
19 designation of its primary State; and

20 “(C) written notice from the issuer of the  
21 issuer’s compliance with all the laws of the pri-  
22 mary State; and

23 “(2) to the insurance commissioner of each sec-  
24 ondary State in which it offers individual health in-  
25 surance coverage, a copy of the issuer’s quarterly fi-

1 nancial statement submitted to the primary State,  
2 which statement shall be certified by an independent  
3 public accountant and contain a statement of opin-  
4 ion on loss and loss adjustment expense reserves  
5 made by—

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

8 “(B) a qualified loss reserve specialist.

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

12 “(1) the solicitation or sale of individual health  
13 insurance coverage by a health insurance issuer to  
14 any person or group who is not eligible for such in-  
15 surance; or

16 “(2) the solicitation or sale of individual health  
17 insurance coverage that violates the requirements of  
18 the law of a secondary State which are described in  
19 subparagraphs (A) through (H) of section  
20 2796(b)(1).

21 “(i) POWER OF SECONDARY STATES TO TAKE AD-  
22 MINISTRATIVE ACTION.—Nothing in this section shall be  
23 construed to affect the authority of any State to enjoin  
24 conduct in violation of that State’s laws described in sec-  
25 tion 2796(b)(1).

1 “(j) STATE POWERS TO ENFORCE STATE LAWS.—

2 “(1) IN GENERAL.—Subject to the provisions of  
3 subsection (b)(1)(G) (relating to injunctions) and  
4 paragraph (2), nothing in this section shall be con-  
5 strued to affect the authority of any State to make  
6 use of any of its powers to enforce the laws of such  
7 State with respect to which a health insurance issuer  
8 is not exempt under subsection (b).

9 “(2) COURTS OF COMPETENT JURISDICTION.—

10 If a State seeks an injunction regarding the conduct  
11 described in paragraphs (1) and (2) of subsection  
12 (h), such injunction must be obtained from a Fed-  
13 eral or State court of competent jurisdiction.

14 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this  
15 section shall affect the authority of any State to bring ac-  
16 tion in any Federal or State court.

17 “(l) GENERALLY APPLICABLE LAWS.—Nothing in  
18 this section shall be construed to affect the applicability  
19 of State laws generally applicable to persons or corpora-  
20 tions.

21 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO  
22 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a  
23 health insurance issuer is offering coverage in a primary  
24 State that does not accommodate residents of secondary  
25 States or does not provide a working mechanism for resi-

1 dents of a secondary State, and the issuer is offering cov-  
2 erage under this part in such secondary State which has  
3 not adopted a qualified high risk pool as its acceptable  
4 alternative mechanism (as defined in section 2744(c)(2)),  
5 the issuer shall, with respect to any individual health in-  
6 surance coverage offered in a secondary State under this  
7 part, comply with the guaranteed availability requirements  
8 for eligible individuals in section 2741.

9 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
10 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
11 **STATES.**

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

18 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
19 **DURES.**

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

24 “(1) both the secondary State and the primary  
25 State have legislation or regulations in place estab-

1 lishing an independent review process for individuals  
2 who are covered by individual health insurance cov-  
3 erage, or

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

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

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

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

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

9 “(C) compensation provided by the issuer  
10 to each reviewer is consistent with paragraph  
11 (6).

12 “(2) LICENSURE AND EXPERTISE.—Each inde-  
13 pendent medical reviewer shall be a physician  
14 (allopathic or osteopathic) or health care profes-  
15 sional who—

16 “(A) is appropriately credentialed or li-  
17 censed in 1 or more States to deliver health  
18 care services; and

19 “(B) typically treats the condition, makes  
20 the diagnosis, or provides the type of treatment  
21 under review.

22 “(3) INDEPENDENCE.—

23 “(A) IN GENERAL.—Subject to subpara-  
24 graph (B), each independent medical reviewer  
25 in a case shall—

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

3 “(ii) not have a material familial, fi-  
4 nancial, or professional relationship with  
5 such a party; and

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

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

11 “(i) prohibit an individual, solely on  
12 the basis of affiliation with the issuer,  
13 from serving as an independent medical re-  
14 viewer if—

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

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

20 “(III) the fact of such an affli-  
21 ation is disclosed to the issuer and the  
22 enrollee (or authorized representative)  
23 and neither party objects; and

24 “(IV) the affiliated individual is  
25 not an employee of the issuer and

1 does not provide services exclusively or  
2 primarily to or on behalf of the issuer;

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

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

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

17 “(A) IN GENERAL.—In a case involving  
18 treatment, or the provision of items or serv-  
19 ices—

20 “(i) by a physician, a reviewer shall be  
21 a practicing physician (allopathic or osteo-  
22 pathic) of the same or similar specialty, as  
23 a physician who, acting within the appro-  
24 priate scope of practice within the State in  
25 which the service is provided or rendered,

1 typically treats the condition, makes the  
2 diagnosis, or provides the type of treat-  
3 ment under review; or

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

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

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

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

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

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

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

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

14 “(B) The enrollee (or authorized represent-  
15 ative).

16 “(C) The health care professional that pro-  
17 vides the items or services involved in the de-  
18 nial.

19 “(D) The institution at which the items or  
20 services (or treatment) involved in the denial  
21 are provided.

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

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

4           “(8) DEFINITIONS.—For purposes of this sub-  
5           section:

6           “(A) ENROLLEE.—The term ‘enrollee’  
7           means, with respect to health insurance cov-  
8           erage offered by a health insurance issuer, an  
9           individual enrolled with the issuer to receive  
10          such coverage.

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

17       **“SEC. 2799. ENFORCEMENT.**

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

23          “(b) SECONDARY STATE’S AUTHORITY.—Nothing in  
24          subsection (a) shall be construed to affect the authority

1 of a secondary State to enforce its laws as set forth in  
2 the exception specified in section 2796(b)(1).

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

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

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

17          (c) GAO ONGOING STUDY AND REPORTS.—

18               (1) STUDY.—The Comptroller General of the  
19 United States shall conduct an ongoing study con-  
20 cerning the effect of the amendment made by sub-  
21 section (a) on—

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

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

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

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

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

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

17 **SEC. 132. SEVERABILITY.**

18 If any provision of this subtitle or the application of  
19 such provision to any person or circumstance is held to  
20 be unconstitutional, the remainder of this subtitle and the  
21 application of the provisions of such to any other person  
22 or circumstance shall not be affected.

1 **Subtitle E—Protecting Patients**  
2 **From Rescissions**

3 **SEC. 141. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
4 **THIRD PARTY REVIEWS OF CERTAIN NON-**  
5 **RENEWALS AND DISCONTINUATIONS, IN-**  
6 **CLUDING RESCISSIONS, OF INDIVIDUAL**  
7 **HEALTH INSURANCE COVERAGE.**

8 (a) CLARIFICATION REGARDING APPLICATION OF  
9 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH  
10 INSURANCE COVERAGE.—Section 2742 of the Public  
11 Health Service Act (42 U.S.C. 300gg-42) is amended—

12 (1) in its heading, by inserting “, continuation  
13 in force, including prohibition of rescission,” after  
14 “guaranteed renewability”;

15 (2) in subsection (a), by inserting “, including  
16 without rescission,” after “continue in force”; and

17 (3) in subsection (b)(2), by inserting before the  
18 period at the end the following: “, including inten-  
19 tional concealment of material facts regarding a  
20 health condition related to the condition for which  
21 coverage is being claimed”.

22 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL  
23 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1  
24 of part B of title XXVII of the Public Health Service Act  
25 is amended by adding at the end the following new section:

1 **“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
 2 **THIRD PARTY REVIEW IN CERTAIN CASES.**

3 “(a) NOTICE AND REVIEW RIGHT.—If a health in-  
 4 surance issuer determines to nonrenew or not continue in  
 5 force, including rescind, health insurance coverage for an  
 6 individual in the individual market on the basis described  
 7 in section 2742(b)(2) before such nonrenewal, discontinu-  
 8 ation, or rescission, may take effect the issuer shall pro-  
 9 vide the individual with notice of such proposed non-  
 10 renewal, discontinuation, or rescission and an opportunity  
 11 for a review of such determination by an independent, ex-  
 12 ternal third party under procedures specified by the Sec-  
 13 retary.

14 “(b) INDEPENDENT DETERMINATION.—If the indi-  
 15 vidual requests such review by an independent, external  
 16 third party of a nonrenewal, discontinuation, or rescission  
 17 of health insurance coverage, the coverage shall remain in  
 18 effect until such third party determines that the coverage  
 19 may be nonrenewed, discontinued, or rescinded under sec-  
 20 tion 2742(b)(2).”

21 (c) EFFECTIVE DATE.—The amendments made by  
 22 this section shall apply after the date of the enactment  
 23 of this Act with respect to health insurance coverage  
 24 issued before, on, or after such date.

1 **TITLE II—PROMOTING PATIENT**  
 2 **CHOICE**  
 3 **Subtitle A—Credit for Small Em-**  
 4 **ployers Adopting Auto-Enroll-**  
 5 **ment and Defined Contribution**  
 6 **Options**

7 **SEC. 201. CREDIT FOR SMALL EMPLOYERS ADOPTING**  
 8 **AUTO-ENROLLMENT AND DEFINED CON-**  
 9 **TRIBUTION OPTIONS.**

10 (a) IN GENERAL.—Subpart D of part IV of sub-  
 11 chapter A of chapter 1 of the Internal Revenue Code of  
 12 1986 (relating to business-related credits) is amended by  
 13 adding at the end the following new section:

14 **“SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBU-**  
 15 **TION OPTION FOR HEALTH BENEFITS PLANS**  
 16 **OF SMALL EMPLOYERS.**

17 “(a) IN GENERAL.—For purposes of section 38, in  
 18 the case of a small employer, the health benefits plan im-  
 19 plementation credit determined under this section for the  
 20 taxable year is an amount equal to 100 percent of the  
 21 amount paid or incurred by the taxpayer during the tax-  
 22 able year for qualified health benefits expenses.

23 “(b) LIMITATION.—The credit determined under sub-  
 24 section (a) with respect to any taxpayer for any taxable  
 25 year shall not exceed the excess of—

1 “(1) \$1,500, over

2 “(2) sum of the credits determined under sub-  
3 section (a) with respect to such taxpayer for all pre-  
4 ceding taxable years.

5 “(c) QUALIFIED HEALTH BENEFITS EXPENSES.—

6 For purposes of this section, the term ‘qualified health  
7 benefits auto-enrollment expenses’ means, with respect to  
8 any taxable year, amounts paid or incurred by the tax-  
9 payer during such taxable year for—

10 “(1) establishing auto-enrollment which meets  
11 the requirements of section 107 of the for coverage  
12 of a participant or beneficiary under a group health  
13 plan, or health insurance coverage offered in connec-  
14 tion with such a plan, and

15 “(2) implementing the employer contribution  
16 option for health insurance coverage pursuant to  
17 section 5000(c)(2).

18 “(d) QUALIFIED SMALL EMPLOYER.—For purposes  
19 of this section, the term ‘qualified small employer’ means  
20 any employer for any taxable year if the number of em-  
21 ployees employed by such employer during such taxable  
22 year does not exceed 50. All employers treated as a single  
23 employer under subsection (a) or (b) of section 52 shall  
24 be treated as a single employer for purposes of this sec-  
25 tion.

1 “(e) NO DOUBLE BENEFIT.—No deduction or credit  
2 shall be allowed under any other provision of this chapter  
3 with respect to the amount of the credit determined under  
4 this section.

5 “(f) TERMINATION.—Subsection (a) shall not apply  
6 to any taxable year beginning after the date which is 2  
7 years after the date of the enactment of this section.”.

8 (b) CREDIT TO BE PART OF GENERAL BUSINESS  
9 CREDIT.—Subsection (b) of section 38 of such Code (re-  
10 lating to general business credit) is amended by striking  
11 “plus” at the end of paragraph (34), by striking the period  
12 at the end of paragraph (35) and inserting “, plus” , and  
13 by adding at the end the following new paragraph:

14 “(36) in the case of a small employer (as de-  
15 fined in section 45R(d)), the health benefits plan im-  
16 plementation credit determined under section  
17 45R(a).”.

18 (c) CLERICAL AMENDMENT.—The table of sections  
19 for subpart D of part IV of subchapter A of chapter 1  
20 of such Code is amended by inserting after the item relat-  
21 ing to section 45Q the following new item:

“Sec. 45R. Auto-enrollment and defined contribution option for health benefits  
plans of small employers.”.

22 (d) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to taxable years beginning after  
24 the date of the enactment of this Act.

**Subtitle B—Tax Incentives for  
Long-Term Care Insurance**

**SEC. 211. TREATMENT OF PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.**

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

**“SEC. 224. PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.**

“(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for coverage for the taxpayer and the taxpayer’s spouse and dependents under a qualified long-term care insurance contract (as defined in section 7702B(b)).

“(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage shall be determined in accordance with the following table:

“For taxable years beginning in calendar year—	The applicable percentage is—
2010 or 2011 .....	25
2012 .....	35
2013 .....	65
2014 or thereafter .....	100.

“(c) COORDINATION WITH OTHER DEDUCTIONS.— Any amount paid by a taxpayer for any qualified long-term care insurance contract to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).”.

**(b) LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—**

(1) CAFETERIA PLANS.—The last sentence of section 125(f) of such Code (defining qualified benefits) is amended by inserting before the period at the end “; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract”.

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (e) and redesignating subsections (d) and (e) as subsections (c) and (d), respectively.

**(c) CONFORMING AMENDMENTS.—**

1 (1) Section 62(a) of such Code is amended by  
2 inserting before the last sentence at the end the fol-  
3 lowing new paragraph:

4 “(22) PREMIUMS ON QUALIFIED LONG-TERM  
5 CARE INSURANCE CONTRACTS.—The deduction al-  
6 lowed by section 224.”.

7 (2) Sections 223(b)(4)(B), 223(d)(4)(C),  
8 223(f)(3)(B), 3231(e)(11), 3306(b)(18),  
9 3401(a)(22), 4973(g)(1), and 4973(g)(2)(B)(i) of  
10 such Code are each amended by striking “section  
11 106(d)” and inserting “section 106(e)”.

12 (3) Section 223(e)(1)(B)(iii)(II) of such Code is  
13 amended by striking “106(e)” and inserting  
14 “106(d)”.

15 (4) Section 6041 of such Code is amended—

16 (A) in subsection (f)(1) by striking “(as  
17 defined in section 106(e)(2))”, and

18 (B) by adding at the end the following new  
19 subsection:

20 “(h) FLEXIBLE SPENDING ARRANGEMENT DE-  
21 FINED.—For purposes of this section, a flexible spending  
22 arrangement is a benefit program which provides employ-  
23 ees with coverage under which—

1 “(1) specified incurred expenses may be reim-  
2 bursed (subject to reimbursement maximums and  
3 other reasonable conditions), and

4 “(2) the maximum amount of reimbursement  
5 which is reasonably available to a participant for  
6 such coverage is less than 500 percent of the value  
7 of such coverage.

8 In the case of an insured plan, the maximum amount rea-  
9 sonably available shall be determined on the basis of the  
10 underlying coverage.”.

11 (5) The table of sections for part VII of sub-  
12 chapter B of chapter 1 of such Code is amended by  
13 striking the last item and inserting the following  
14 new items:

“Sec. 224. Premiums on qualified long-term care insurance contracts.  
“Sec. 225. Cross reference.”.

15 (d) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply to taxable years beginning after  
17 December 31, 2009.

18 **SEC. 212. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE**  
19 **NEEDS.**

20 (a) IN GENERAL.—Subpart A of part IV of sub-  
21 chapter A of chapter 1 of the Internal Revenue Code of  
22 1986 (relating to nonrefundable personal credits) is  
23 amended by inserting after section 25D the following new  
24 section:

1 **"SEC. 25E. CREDIT FOR TAXPAYERS WITH LONG-TERM**  
 2 **CARE NEEDS.**

3 **"(a) ALLOWANCE OF CREDIT.—**

4 **"(1) IN GENERAL.—**There shall be allowed as a  
 5 credit against the tax imposed by this chapter for  
 6 the taxable year an amount equal to the applicable  
 7 credit amount multiplied by the number of applica-  
 8 ble individuals with respect to whom the taxpayer is  
 9 an eligible caregiver for the taxable year.

10 **"(2) APPLICABLE CREDIT AMOUNT.—**For pur-  
 11 poses of paragraph (1), the applicable credit amount  
 12 shall be determined in accordance with the following  
 13 table:

<b>"For taxable years beginning in calendar year—</b>	<b>The applicable credit amount is—</b>
2010 .....	1,500
2011 .....	2,000
2012 .....	2,500
2013 or thereafter .....	3,000.

14 **"(b) LIMITATION BASED ON ADJUSTED GROSS IN-**  
 15 **COME.—**

16 **"(1) IN GENERAL.—**The amount of the credit  
 17 allowable under subsection (a) shall be reduced (but  
 18 not below zero) by \$100 for each \$1,000 (or fraction  
 19 thereof) by which the taxpayer's modified adjusted  
 20 gross income exceeds the threshold amount. For  
 21 purposes of the preceding sentence, the term 'modi-  
 22 fied adjusted gross income' means adjusted gross in-

1 come increased by any amount excluded from gross  
 2 income under section 911, 931, or 933.

3 **"(2) THRESHOLD AMOUNT.—**For purposes of  
 4 paragraph (1), the term 'threshold amount' means—

5 **"(A)** \$150,000 in the case of a joint re-  
 6 turn, and

7 **"(B)** \$75,000 in any other case.

8 **"(3) INDEXING.—**In the case of any taxable  
 9 year beginning in a calendar year after 2010, each  
 10 dollar amount contained in paragraph (2) shall be  
 11 increased by an amount equal to the product of—

12 **"(A)** such dollar amount, and

13 **"(B)** the medical care cost adjustment de-  
 14 termined under section 213(d)(10)(B)(ii) for  
 15 the calendar year in which the taxable year be-  
 16 gins, determined by substituting 'August 2009'  
 17 for 'August 1996' in subclause (II) thereof.

18 If any increase determined under the preceding sen-  
 19 tence is not a multiple of \$50, such increase shall  
 20 be rounded to the next lowest multiple of \$50.

21 **"(c) DEFINITIONS.—**For purposes of this section:

22 **"(1) APPLICABLE INDIVIDUAL.—**

23 **"(A) IN GENERAL.—**The term 'applicable  
 24 individual' means, with respect to any taxable  
 25 year, any individual who has been certified, be-

1 fore the due date for filing the return of tax for  
 2 the taxable year (without extensions), by a phy-  
 3 sician (as defined in section 1861(r)(1) of the  
 4 Social Security Act) as being an individual with  
 5 long-term care needs described in subparagraph  
 6 (B) for a period—

7 “(i) which is at least 180 consecutive  
 8 days, and

9 “(ii) a portion of which occurs within  
 10 the taxable year.

11 Notwithstanding the preceding sentence, a cer-  
 12 tification shall not be treated as valid unless it  
 13 is made within the 39½ month period ending  
 14 on such due date (or such other period as the  
 15 Secretary prescribes).

16 “(B) INDIVIDUALS WITH LONG-TERM CARE  
 17 NEEDS.—An individual is described in this sub-  
 18 paragraph if the individual meets any of the fol-  
 19 lowing requirements:

20 “(i) The individual is at least 6 years  
 21 of age and—

22 “(I) is unable to perform (with-  
 23 out substantial assistance from an-  
 24 other individual) at least 3 activities  
 25 of daily living (as defined in section

1 7702B(c)(2)(B)) due to a loss of  
 2 functional capacity, or

3 “(II) requires substantial super-  
 4 vision to protect such individual from  
 5 threats to health and safety due to se-  
 6 vere cognitive impairment and is un-  
 7 able to perform, without reminding or  
 8 cuing assistance, at least 1 activity of  
 9 daily living (as so defined) or to the  
 10 extent provided in regulations pre-  
 11 scribed by the Secretary (in consulta-  
 12 tion with the Secretary of Health and  
 13 Human Services), is unable to engage  
 14 in age appropriate activities.

15 “(ii) The individual is at least 2 but  
 16 not 6 years of age and is unable due to a  
 17 loss of functional capacity to perform  
 18 (without substantial assistance from an-  
 19 other individual) at least 2 of the following  
 20 activities: eating, transferring, or mobility.

21 “(iii) The individual is under 2 years  
 22 of age and requires specific durable med-  
 23 ical equipment by reason of a severe health  
 24 condition or requires a skilled practitioner  
 25 trained to address the individual’s condi-

1           tion to be available if the individual's par-  
2           ents or guardians are absent.

3           “(2) ELIGIBLE CAREGIVER.—

4           “(A) IN GENERAL.—A taxpayer shall be  
5           treated as an eligible caregiver for any taxable  
6           year with respect to the following individuals:

7           “(i) The taxpayer.

8           “(ii) The taxpayer's spouse.

9           “(iii) An individual with respect to  
10          whom the taxpayer is allowed a deduction  
11          under section 151(e) for the taxable year.

12          “(iv) An individual who would be de-  
13          scribed in clause (iii) for the taxable year  
14          if section 151(e) were applied by sub-  
15          stituting for the exemption amount an  
16          amount equal to the sum of the exemption  
17          amount, the standard deduction under sec-  
18          tion 63(c)(2)(C), and any additional stand-  
19          ard deduction under section 63(e)(3) which  
20          would be applicable to the individual if  
21          clause (iii) applied.

22          “(v) An individual who would be de-  
23          scribed in clause (iii) for the taxable year  
24          if—

1           “(I) the requirements of clause  
2           (iv) are met with respect to the indi-  
3           vidual, and

4           “(II) the requirements of sub-  
5           paragraph (B) are met with respect to  
6           the individual in lieu of the support  
7           test under subsection (c)(1)(D) or  
8           (d)(1)(C) of section 152.

9           “(B) RESIDENCY TEST.—The require-  
10          ments of this subparagraph are met if an indi-  
11          vidual has as his principal place of abode the  
12          home of the taxpayer and—

13          “(i) in the case of an individual who  
14          is an ancestor or descendant of the tax-  
15          payer or the taxpayer's spouse, is a mem-  
16          ber of the taxpayer's household for over  
17          half the taxable year, or

18          “(ii) in the case of any other indi-  
19          vidual, is a member of the taxpayer's  
20          household for the entire taxable year.

21          “(C) SPECIAL RULES WHERE MORE THAN  
22          1 ELIGIBLE CAREGIVER.—

23          “(i) IN GENERAL.—If more than 1 in-  
24          dividual is an eligible caregiver with re-  
25          spect to the same applicable individual for

1 taxable years ending with or within the  
2 same calendar year, a taxpayer shall be  
3 treated as the eligible caregiver if each  
4 such individual (other than the taxpayer)  
5 files a written declaration (in such form  
6 and manner as the Secretary may pre-  
7 scribe) that such individual will not claim  
8 such applicable individual for the credit  
9 under this section.

10 “(ii) NO AGREEMENT.—If each indi-  
11 vidual required under clause (i) to file a  
12 written declaration under clause (i) does  
13 not do so, the individual with the highest  
14 adjusted gross income shall be treated as  
15 the eligible caregiver.

16 “(iii) MARRIED INDIVIDUALS FILING  
17 SEPARATELY.—In the case of married indi-  
18 viduals filing separately, the determination  
19 under this subparagraph as to whether the  
20 husband or wife is the eligible caregiver  
21 shall be made under the rules of clause (ii)  
22 (whether or not one of them has filed a  
23 written declaration under clause (i)).

24 “(d) IDENTIFICATION REQUIREMENT.—No credit  
25 shall be allowed under this section to a taxpayer with re-

1 spect to any applicable individual unless the taxpayer in-  
2 cludes the name and taxpayer identification number of  
3 such individual, and the identification number of the phy-  
4 sician certifying such individual, on the return of tax for  
5 the taxable year.

6 “(e) TAXABLE YEAR MUST BE FULL TAXABLE  
7 YEAR.—Except in the case of a taxable year closed by rea-  
8 son of the death of the taxpayer, no credit shall be allow-  
9 able under this section in the case of a taxable year cov-  
10 ering a period of less than 12 months.”.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Section 6213(g)(2) of such Code is amend-  
13 ed by striking “and” at the end of subparagraph  
14 (L), by striking the period at the end of subpara-  
15 graph (M) and inserting “, and”, and by inserting  
16 after subparagraph (M) the following new subpara-  
17 graph:

18 “(N) an omission of a correct TIN or phy-  
19 sician identification required under section  
20 25E(d) (relating to credit for taxpayers with  
21 long-term care needs) to be included on a re-  
22 turn.”.

23 (2) The table of sections for subpart A of part  
24 IV of subchapter A of chapter 1 of such Code is

1 amended by inserting after the item relating to sec-  
2 tion 25D the following new item:

“Sec. 25E. Credit for taxpayers with long-term care needs.”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to taxable years beginning after  
5 December 31, 2009.

6 **SEC. 213. ADDITIONAL CONSUMER PROTECTIONS FOR**  
7 **LONG-TERM CARE INSURANCE.**

8 (a) ADDITIONAL PROTECTIONS APPLICABLE TO  
9 LONG-TERM CARE INSURANCE.—Subparagraphs (A) and  
10 (B) of section 7702B(g)(2) of the Internal Revenue Code  
11 of 1986 (relating to requirements of model regulation and  
12 Act) are amended to read as follows:

13 “(A) IN GENERAL.—The requirements of  
14 this paragraph are met with respect to any con-  
15 tract if such contract meets—

16 “(i) MODEL REGULATION.—The fol-  
17 lowing requirements of the model regula-  
18 tion:

19 “(I) Section 6A (relating to guar-  
20 anteed renewal or noncancellability),  
21 other than paragraph (5) thereof, and  
22 the requirements of section 6B of the  
23 model Act relating to such section 6A.

24 “(II) Section 6B (relating to pro-  
25 hibitions on limitations and exclu-

1 sions) other than paragraph (7) there-  
2 of.

3 “(III) Section 6C (relating to ex-  
4 tension of benefits).

5 “(IV) Section 6D (relating to  
6 continuation or conversion of cov-  
7 erage).

8 “(V) Section 6E (relating to dis-  
9 continuance and replacement of poli-  
10 cies).

11 “(VI) Section 7 (relating to unin-  
12 tentional lapse).

13 “(VII) Section 8 (relating to dis-  
14 closure), other than sections 8F, 8G,  
15 8H, and 8I thereof.

16 “(VIII) Section 11 (relating to  
17 prohibitions against post-claims un-  
18 derwriting).

19 “(IX) Section 12 (relating to  
20 minimum standards).

21 “(X) Section 13 (relating to re-  
22 quirement to offer inflation protec-  
23 tion).

24 “(XI) Section 25 (relating to pro-  
25 hibition against preexisting conditions

1 and probationary periods in replace-  
2 ment policies or certificates).

3 “(XII) The provisions of section  
4 26 relating to contingent nonforfeiture  
5 benefits, if the policyholder declines  
6 the offer of a nonforfeiture provision  
7 described in paragraph (4).

8 “(ii) MODEL ACT.—The following re-  
9 quirements of the model Act:

10 “(I) Section 6C (relating to pre-  
11 existing conditions).

12 “(II) Section 6D (relating to  
13 prior hospitalization).

14 “(III) The provisions of section 8  
15 relating to contingent nonforfeiture  
16 benefits, if the policyholder declines  
17 the offer of a nonforfeiture provision  
18 described in paragraph (4).

19 “(B) DEFINITIONS.—For purposes of this  
20 paragraph:

21 “(i) MODEL PROVISIONS.—The terms  
22 ‘model regulation’ and ‘model Act’ mean  
23 the long-term care insurance model regula-  
24 tion, and the long-term care insurance  
25 model Act, respectively, promulgated by

1 the National Association of Insurance  
2 Commissioners (as adopted as of December  
3 31, 2008).

4 “(ii) COORDINATION.—Any provision  
5 of the model regulation or model Act listed  
6 under clause (i) or (ii) of subparagraph  
7 (A) shall be treated as including any other  
8 provision of such regulation or Act nec-  
9 essary to implement the provision.

10 “(iii) DETERMINATION.—For pur-  
11 poses of this section and section 4980C,  
12 the determination of whether any require-  
13 ment of a model regulation or the model  
14 Act has been met shall be made by the  
15 Secretary.”

16 (b) EXCISE TAX.—Paragraph (1) of section  
17 4980C(c) of the Internal Revenue Code of 1986 (relating  
18 to requirements of model provisions) is amended to read  
19 as follows:

20 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

21 “(A) MODEL REGULATION.—The following  
22 requirements of the model regulation must be  
23 met:

24 “(i) Section 9 (relating to required  
25 disclosure of rating practices to consumer).

1           “(ii) Section 14 (relating to applica-  
2           tion forms and replacement coverage).

3           “(iii) Section 15 (relating to reporting  
4           requirements).

5           “(iv) Section 22 (relating to filing re-  
6           quirements for marketing).

7           “(v) Section 23 (relating to standards  
8           for marketing), including inaccurate com-  
9           pletion of medical histories, other than  
10          paragraphs (1), (6), and (9) of section  
11          23C.

12          “(vi) Section 24 (relating to suit-  
13          ability).

14          “(vii) Section 29 (relating to standard  
15          format outline of coverage).

16          “(viii) Section 30 (relating to require-  
17          ment to deliver shopper’s guide).

18          The requirements referred to in clause (vi) shall  
19          not include those portions of the personal work-  
20          sheet described in Appendix B relating to con-  
21          sumer protection requirements not imposed by  
22          section 4980C or 7702B.

23          “(B) MODEL ACT.—The following require-  
24          ments of the model Act must be met:

1           “(i) Section 6F (relating to right to  
2           return).

3           “(ii) Section 6G (relating to outline of  
4           coverage).

5           “(iii) Section 6H (relating to require-  
6           ments for certificates under group plans).

7           “(iv) Section 6J (relating to policy  
8           summary).

9           “(v) Section 6K (relating to monthly  
10          reports on accelerated death benefits).

11          “(vi) Section 7 (relating to incontest-  
12          ability period).

13          “(C) DEFINITIONS.—For purposes of this  
14          paragraph, the terms ‘model regulation’ and  
15          ‘model Act’ have the meanings given such terms  
16          by section 7702B(g)(2)(B).”.

17          (e) EFFECTIVE DATE.—The amendments made by  
18          this section shall apply to policies issued after December  
19          31, 2009.

1           **Subtitle C—Comparative**  
 2           **Effectiveness Research**

3   **SEC. 221. PROHIBITION ON CERTAIN USES OF DATA OB-**  
 4           **TAINED FROM COMPARATIVE EFFECTIVE-**  
 5           **NESS RESEARCH; ACCOUNTING FOR PERSON-**  
 6           **ALIZED MEDICINE AND DIFFERENCES IN PA-**  
 7           **TIENT TREATMENT RESPONSE.**

8           (a) IN GENERAL.—Notwithstanding any other provi-  
 9 sion of law, the Secretary of Health and Human Serv-  
 10 ices—

11           (1) shall not use data obtained from the con-  
 12 duct of comparative effectiveness research, including  
 13 such research that is conducted or supported using  
 14 funds appropriated under the American Recovery  
 15 and Reinvestment Act of 2009 (Public Law 111–5),  
 16 to deny coverage of an item or service under a Fed-  
 17 eral health care program (as defined in section  
 18 1128B(f) of the Social Security Act (42 U.S.C.  
 19 1320a–7b(f))); and

20           (2) shall ensure that comparative effectiveness  
 21 research conducted or supported by the Federal  
 22 Government accounts for factors contributing to dif-  
 23 ferences in the treatment response and treatment  
 24 preferences of patients, including patient-reported  
 25 outcomes, genomics and personalized medicine, the

1           unique needs of health disparity populations, and in-  
 2           direct patient benefits.

3           (b) RULE OF CONSTRUCTION.—Nothing in this sec-  
 4 tion shall be construed as affecting the authority of the  
 5 Commissioner of Food and Drugs under the Federal  
 6 Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.)  
 7 or the Public Health Service Act (42 U.S.C. 201 et seq.).

8           **Subtitle D—Programs of Health**  
 9           **Promotion or Disease Prevention**

10   **SEC. 231. PROGRAMS OF HEALTH PROMOTION OR DISEASE**  
 11           **PREVENTION.**

12           (a) IN GENERAL.—Nothing in the Public Health  
 13 Service Act, Employee Retirement Income Security Act of  
 14 1974, or the Internal Revenue Code of 1986 (or any  
 15 amendment made by this Act) shall be applied, adminis-  
 16 tered, or interpreted to prevent an employer from estab-  
 17 lishing premium discounts or rebates, or modifying copay-  
 18 ments or deductibles, in the case of employees who adhere  
 19 to, or participate in, a program of health promotion or  
 20 disease prevention which meets the requirements of sub-  
 21 section (b).

22           (b) PROGRAMS OF HEALTH PROMOTION OR DISEASE  
 23 PREVENTION TO WHICH SECTION APPLIES.—

24           (1) GENERAL PROVISIONS.—

1 (A) GENERAL RULE.—For purposes of  
2 paragraph (2)(B), a program of health pro-  
3 motion or disease prevention (referred to in this  
4 subsection as a “wellness program”) shall be a  
5 program that is designed to promote health or  
6 prevent disease that meets the applicable re-  
7 quirements of this subsection.

8 (B) NO CONDITIONS BASED ON HEALTH  
9 STATUS FACTOR.—If none of the conditions for  
10 obtaining a premium discount or rebate or  
11 other reward for participation in a wellness pro-  
12 gram is based on an individual satisfying a  
13 standard that is related to a health status fac-  
14 tor, such wellness program shall not violate this  
15 section if participation in the program is made  
16 available to all similarly situated individuals  
17 and the requirements of paragraph (2) are com-  
18 plied with.

19 (C) CONDITIONS BASED ON HEALTH STA-  
20 TUS FACTOR.—If any of the conditions for ob-  
21 taining a premium discount or rebate or other  
22 reward for participation in a wellness program  
23 is based on an individual satisfying a standard  
24 that is related to a health status factor, such  
25 wellness program shall not violate this section if

1 the requirements of paragraph (3) are complied  
2 with.

3 (2) WELLNESS PROGRAMS NOT SUBJECT TO  
4 REQUIREMENTS.—If none of the conditions for ob-  
5 taining a premium discount or rebate or other re-  
6 ward under a wellness program as described in para-  
7 graph (1)(B) are based on an individual satisfying  
8 a standard that is related to a health status factor  
9 (or if such a wellness program does not provide such  
10 a reward), the wellness program shall not violate  
11 this section if participation in the program is made  
12 available to all similarly situated individuals. The  
13 following programs shall not have to comply with the  
14 requirements of paragraph (3) if participation in the  
15 program is made available to all similarly situated  
16 individuals:

17 (A) A program that reimburses all or part  
18 of the cost for memberships in a fitness center.

19 (B) A diagnostic testing program that pro-  
20 vides a reward for participation and does not  
21 base any part of the reward on outcomes.

22 (C) A program that encourages preventive  
23 care related to a health condition through the  
24 waiver of the copayment or deductible require-  
25 ment under an individual or group health plan

1 for the costs of certain items or services related  
2 to a health condition (such as prenatal care or  
3 well-baby visits).

4 (D) A program that reimburses individuals  
5 for the costs of smoking cessation programs  
6 without regard to whether the individual quits  
7 smoking.

8 (E) A program that provides a reward to  
9 individuals for attending a periodic health edu-  
10 cation seminar.

11 (3) WELLNESS PROGRAMS SUBJECT TO RE-  
12 QUIREMENTS.—If any of the conditions for obtaining  
13 a premium discount, rebate, or reward under a  
14 wellness program as described in paragraph (1)(C)  
15 is based on an individual satisfying a standard that  
16 is related to a health status factor, the wellness pro-  
17 gram shall not violate this section if the following re-  
18 quirements are complied with:

19 (A) The reward for the wellness program,  
20 together with the reward for other wellness pro-  
21 grams with respect to the plan that requires  
22 satisfaction of a standard related to a health  
23 status factor, shall not exceed 50 percent of the  
24 cost of employee-only coverage under the plan.  
25 If, in addition to employees or individuals, any

1 class of dependents (such as spouses or spouses  
2 and dependent children) may participate fully  
3 in the wellness program, such reward shall not  
4 exceed 50 percent of the cost of the coverage in  
5 which an employee or individual and any de-  
6 pendants are enrolled. For purposes of this  
7 paragraph, the cost of coverage shall be deter-  
8 mined based on the total amount of employer  
9 and employee contributions for the benefit  
10 package under which the employee is (or the  
11 employee and any dependents are) receiving  
12 coverage. A reward may be in the form of a dis-  
13 count or rebate of a premium or contribution,  
14 a waiver of all or part of a cost-sharing mecha-  
15 nism (such as deductibles, copayments, or coin-  
16 surance), the absence of a surcharge, or the  
17 value of a benefit that would otherwise not be  
18 provided under the plan.

19 (B) The wellness program shall be reason-  
20 ably designed to promote health or prevent dis-  
21 ease. A program complies with the preceding  
22 sentence if the program has a reasonable  
23 chance of improving the health of, or preventing  
24 disease in, participating individuals and it is  
25 not overly burdensome, is not a subterfuge for

1 discriminating based on a health status factor,  
2 and is not highly suspect in the method chosen  
3 to promote health or prevent disease. The plan  
4 or issuer shall evaluate the program's reason-  
5 ableness at least once per year.

6 (C) The plan shall give individuals eligible  
7 for the program the opportunity to qualify for  
8 the reward under the program at least once  
9 each year.

10 (D) The full reward under the wellness  
11 program shall be made available to all similarly  
12 situated individuals. For such purpose, the fol-  
13 lowing applies:

14 (i) The reward is not available to all  
15 similarly situated individuals for a period  
16 unless the wellness program allows—

17 (I) for a reasonable alternative  
18 standard (or waiver of the otherwise  
19 applicable standard) for obtaining the  
20 reward for any individual for whom,  
21 for that period, it is unreasonably dif-  
22 ficult due to a medical condition to  
23 satisfy the otherwise applicable stand-  
24 ard; and

1 (II) for a reasonable alternative  
2 standard (or waiver of the otherwise  
3 applicable standard) for obtaining the  
4 reward for any individual for whom,  
5 for that period, it is medically inadvis-  
6 able to attempt to satisfy the other-  
7 wise applicable standard.

8 (ii) If reasonable under the cir-  
9 cumstances, the plan or issuer may seek  
10 verification, such as a statement from an  
11 individual's physician, that a health status  
12 factor makes it unreasonably difficult or  
13 medically inadvisable for the individual to  
14 satisfy or attempt to satisfy the otherwise  
15 applicable standard.

16 (E) The plan or issuer involved shall dis-  
17 close in all plan materials describing the terms  
18 of the wellness program the availability of a  
19 reasonable alternative standard (or the possi-  
20 bility of waiver of the otherwise applicable  
21 standard) required under subparagraph (D). If  
22 plan materials disclose that such a program is  
23 available, without describing its terms, the dis-  
24 closure under this subparagraph shall not be re-  
25 quired.

1 (e) EXISTING PROGRAMS.—Nothing in this section  
2 shall prohibit a program of health promotion or disease  
3 prevention that was established prior to the date of enact-  
4 ment of this section and applied with all applicable regula-  
5 tions, and that is operating on such date, from continuing  
6 to be carried out for as long as such regulations remain  
7 in effect.

8 (d) REGULATIONS.—Nothing in this section shall be  
9 construed as prohibiting the Secretaries of Labor, Health  
10 and Human Services, or the Treasury from promulgating  
11 regulations in connection with this section.

12 **TITLE III—STRENGTHENING**  
13 **SAFETY NET PROGRAMS**  
14 **Subtitle A—Beneficiary Choice**  
15 **Under Medicaid and SCHIP**

16 **SEC. 301. EASING ADMINISTRATIVE BARRIERS TO STATE**  
17 **COOPERATION WITH EMPLOYER-SPONSORED**  
18 **INSURANCE COVERAGE.**

19 (a) REQUIRING SOME COVERAGE FOR EMPLOYER-  
20 SPONSORED INSURANCE.—

21 (1) IN GENERAL.—Section 2102(a) of the So-  
22 cial Security Act (42 U.S.C. 1397b(a)) is amend-  
23 ed—

24 (A) in paragraph (6), by striking “and” at  
25 the end;

1 (B) in paragraph (7), by striking the pe-  
2 riod at the end and inserting “; and”; and

3 (C) by adding at the end the following new  
4 paragraph:

5 “(8) effective for plan years beginning on or  
6 after October 1, 2010, how the plan will provide for  
7 child health assistance with respect to targeted low-  
8 income children who have access to coverage under  
9 a group health plan.”.

10 (2) EFFECTIVE DATE.—The amendments made  
11 by paragraph (1) shall apply beginning with fiscal  
12 year 2011.

13 (b) FEDERAL FINANCIAL PARTICIPATION FOR EM-  
14 PLOYER-SPONSORED INSURANCE.—Section 2105 of such  
15 Act (42 U.S.C. 1397d) is amended—

16 (1) in subsection (a)(1)(C), by inserting before  
17 the semicolon at the end the following: “and, subject  
18 to paragraph (3)(C) of subsection (c), in the form of  
19 payment of the premiums for coverage under a  
20 group health plan that includes coverage of targeted  
21 low-income children and benefits supplemental to  
22 such coverage”; and

23 (2) by amending paragraph (3) of subsection  
24 (c) to read as follows:

1           “(3) PURCHASE OF EMPLOYER-SPONSORED IN-  
2           SURANCE.—

3           “(A) IN GENERAL.—Payment may be  
4           made to a State under subsection (a)(1)(C),  
5           subject to the provisions of this paragraph, for  
6           the purchase of family coverage under a group  
7           health plan that includes coverage of targeted  
8           low-income children unless such coverage would  
9           otherwise substitute for coverage that would be  
10          provided to such children but for the purchase  
11          of family coverage.

12          “(B) WAIVER OF CERTAIN PROVISIONS.—  
13          With respect to coverage described in subpara-  
14          graph (A)—

15                 “(i) notwithstanding section 2102, no  
16                 minimum benefits requirement (other than  
17                 those otherwise applicable with respect to  
18                 services within the categories of basic serv-  
19                 ices described in section 2103(c)(1) and  
20                 emergency services) under this title shall  
21                 apply; and

22                 “(ii) no limitation on beneficiary cost-  
23                 sharing otherwise applicable under this  
24                 title or title XIX shall apply.

1           “(C) REQUIRED PROVISION OF SUPPLE-  
2           MENTAL BENEFITS.—If the coverage described  
3           in subparagraph (A) does not provide coverage  
4           for the services in each of the categories of  
5           basic services described in section 2103(c)(1)  
6           and for emergency services, the State child  
7           health plan shall provide coverage of such serv-  
8           ices as supplemental benefits.

9           “(D) LIMITATION ON FFP.—The amount  
10          of the payment under subsection (a)(1)(C) for  
11          coverage described in subparagraph (A) (and  
12          supplemental benefits under subparagraph (C)  
13          for individuals so covered) during a fiscal year  
14          may not exceed the product of—

15                 “(i) the national per capita expendi-  
16                 ture under this title (taking into account  
17                 both Federal and State expenditures) for  
18                 the previous fiscal year (as determined by  
19                 the Secretary using the best available  
20                 data);

21                 “(ii) the enhanced FMAP for the  
22                 State and fiscal year involved; and

23                 “(iii) the number of targeted low-in-  
24                 come children for whom such coverage is  
25                 provided.

1           “(E) VOLUNTARY ENROLLMENT.—A State  
2 child health plan—

3           “(i) may not require a targeted low-  
4 income child to enroll in family coverage  
5 described in subparagraph (A) in order to  
6 obtain child health assistance under this  
7 title;

8           “(ii) before providing such child  
9 health assistance for such coverage of a  
10 child, shall make available (which may be  
11 through an Internet website or other  
12 means) to the parent or guardian of the  
13 child information on the coverage available  
14 under this title, including benefits and  
15 cost-sharing; and

16           “(iii) shall provide at least one oppor-  
17 tunity per fiscal year for beneficiaries to  
18 switch coverage under this title from cov-  
19 erage described in subparagraph (A) to the  
20 coverage that is otherwise made available  
21 under this title.

22           “(F) INFORMATION ON COVERAGE OP-  
23 TIONS.—A State child health plan shall—

1           “(i) describe how the State will notify  
2 potential beneficiaries of coverage de-  
3 scribed in subparagraph (A);

4           “(ii) provide such notification in writ-  
5 ing at least during the initial application  
6 for enrollment under this title and during  
7 redeterminations of eligibility if the indi-  
8 vidual was enrolled before October 1, 2009;  
9 and

10           “(iii) post a description of these cov-  
11 erage options on any official Internet  
12 website that may be established by the  
13 State in connection with the plan.

14           “(G) SEMIANNUAL VERIFICATION OF COV-  
15 ERAGE.—If coverage described in subparagraph  
16 (A) is provided under a group health plan with  
17 respect to a targeted low-income child, the  
18 State child health plan shall provide for the col-  
19 lection, at least once every six months, of proof  
20 from the plan that the child is enrolled in such  
21 coverage.

22           “(H) RULE OF CONSTRUCTION.—Nothing  
23 in this section is to be construed to prohibit a  
24 State from—

1           “(i) offering wrap around benefits in  
2           order for a group health plan to meet any  
3           State-established minimum benefit require-  
4           ments;  
5           “(ii) establishing a cost-effectiveness  
6           test to qualify for coverage under such a  
7           plan;  
8           “(iii) establishing limits on beneficiary  
9           cost-sharing under such a plan;  
10           “(iv) paying all or part of a bene-  
11           ficiary’s cost-sharing requirements under  
12           such a plan;  
13           “(v) paying less than the full cost of  
14           the employee’s share of the premium under  
15           such a plan, including prorating the cost of  
16           the premium to pay for only what the  
17           State determines is the portion of the pre-  
18           mium that covers targeted low-income chil-  
19           dren;  
20           “(vi) using State funds to pay for  
21           benefits above the Federal upper limit es-  
22           tablished under subparagraph (D);  
23           “(vii) allowing beneficiaries enrolled in  
24           group health plans from changing plans to

1           another coverage option available under  
2           this title at any time; or  
3           “(viii) providing any guidance or in-  
4           formation it deems appropriate in order to  
5           help beneficiaries make an informed deci-  
6           sion regarding the option to enroll in cov-  
7           erage described in subparagraph (A).  
8           “(I) GROUP HEALTH PLAN DEFINED.—In  
9           this paragraph, the term ‘group health plan’  
10           has the meaning given such term in section  
11           2791(a)(1) of the Public Health Service Act (42  
12           U.S.C. 300gg–91(a)(1)).  
13           “(J) ATTESTATION REQUIREMENT FOR  
14           CERTAIN HIGHER INCOME CHILDREN.—Effec-  
15           tive October 1, 2011, any State that provides  
16           for child health assistance under this title for  
17           children in families with gross income (as deter-  
18           mined without regard to any income disregards  
19           or expense exclusions) that exceeds 200 percent  
20           of the poverty line shall require, as a condition  
21           of eligibility for child health assistance under  
22           this title (other than in the form of premium  
23           assistance under this paragraph) that there  
24           must be executed an attestation (under penalty

1 of perjury) that the child is not eligible for cov-  
2 erage under any group health plan.”.

3 **SEC. 302. IMPROVING BENEFICIARY CHOICE IN SCHIP.**

4 (a) **REQUIRING OFFERING OF ALTERNATIVE COV-**  
5 **ERAGE OPTIONS.**—Section 2102 of the Social Security Act  
6 (42 U.S.C. 1397b), as amended by section 1781, is  
7 amended—

8 (1) in subsection (a)—

9 (A) in paragraph (7), by striking “and” at  
10 the end;

11 (B) in paragraph (8), by striking the pe-  
12 riod at the end and inserting “; and”; and

13 (C) by adding at the end the following new  
14 paragraph:

15 “(9) effective for plan years beginning on or  
16 after October 1, 2010, how the plan will provide for  
17 child health assistance with respect to targeted low-  
18 income children through alternative coverage options  
19 in accordance with subsection (d).”; and

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

22 “(d) **ALTERNATIVE COVERAGE OPTIONS.**—

23 “(1) **IN GENERAL.**—Effective October 1, 2010,  
24 a State child health plan shall provide for the offer-  
25 ing of any qualified alternative coverage that a

1 qualified entity seeks to offer to targeted low-income  
2 children through the plan in the State.

3 “(2) **APPLICATION OF UNIFORM FINANCIAL**  
4 **LIMITATION FOR ALL ALTERNATIVE COVERAGE OP-**  
5 **TIONS.**—With respect to all qualified alternative cov-  
6 erage offered in a State, the State child health plan  
7 shall establish a uniform dollar limitation on the per  
8 capita monthly amount that will be paid by the  
9 State to the qualified entity with respect to such  
10 coverage provided to a targeted low-income child.  
11 Such limitation may not be less than 90 percent of  
12 the per capita monthly payment made for coverage  
13 offered under the State child health plan that is not  
14 in the form of an alternative coverage option. Noth-  
15 ing in this paragraph shall be construed—

16 “(A) as requiring a State to provide for  
17 the full payment of premiums for qualified al-  
18 ternative coverage;

19 “(B) as preventing a State from charging  
20 additional premiums to cover the difference be-  
21 tween the cost of qualified alternative coverage  
22 and the amount of such payment limitation;

23 “(C) as preventing a State from using its  
24 own funds to provide a dollar limitation that ex-

1 ceeds the Federal financial participation as limited under section 2105(c)(8).

2  
3 “(3) QUALIFIED ALTERNATIVE COVERAGE DEFINED.—In this section, the term ‘qualified alternative coverage’ means health insurance coverage that—

4  
5  
6  
7 “(A) meets the coverage requirements of section 2103 (other than cost-sharing requirements of such section); and

8  
9  
10 “(B) is offered by a qualified insurer, and not directly by the State.

11  
12 “(4) QUALIFIED INSURER DEFINED.—In this section, the term ‘qualified insurer’ means, with respect to a State, an entity that is licensed to offer health insurance coverage in the State.”.

13  
14  
15  
16 (b) FEDERAL FINANCIAL PARTICIPATION FOR QUALIFIED ALTERNATIVE COVERAGE.—Section 2105 of such Act (42 U.S.C. 1397d), as amended by sections 17 301(a) and 601(a) of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–21 5), is amended—

22 (1) in subsection (a)(1)(C), as amended by section 23 1781(b)(1), by inserting before the semicolon at 24 the end the following: “and, subject to subsection

1 (e)(12)(C), in the form of payment of the premiums  
2 for coverage for qualified alternative coverage”; and  
3 (2) by adding at the end of subsection (c) the  
4 following new paragraph:

5 “(12) PURCHASE OF QUALIFIED ALTERNATIVE  
6 COVERAGE.—

7 “(A) IN GENERAL.—Payment may be  
8 made to a State under subsection (a)(1)(C),  
9 subject to the provisions of this paragraph, for  
10 the purchase of qualified alternative coverage.

11 “(B) WAIVER OF CERTAIN PROVISIONS.—  
12 With respect to coverage described in subparagraph (A), no limitation on beneficiary cost-sharing otherwise applicable under this title or title XIX shall apply.

13  
14  
15  
16 “(C) LIMITATION ON FFP.—The amount of  
17 the payment under paragraph (1)(C) for coverage described in subparagraph (A) during a  
18 fiscal year in the aggregate for all such coverage in the State may not exceed the product  
19 of—  
20  
21

22 “(i) the national per capita expenditure under this title (taking into account  
23 both Federal and State expenditures) for  
24 the previous fiscal year (as determined by  
25

1 the Secretary using the best available  
2 data);

3 “(ii) the enhanced FMAP for the  
4 State and fiscal year involved; and

5 “(iii) the number of targeted low-in-  
6 come children for whom such coverage is  
7 provided.

8 “(D) VOLUNTARY ENROLLMENT.—A State  
9 child health plan—

10 “(i) may not require a targeted low-  
11 income child to enroll in coverage described  
12 in subparagraph (A) in order to obtain  
13 child health assistance under this title;

14 “(ii) before providing such child  
15 health assistance for such coverage of a  
16 child, shall make available (which may be  
17 through an Internet website or other  
18 means) to the parent or guardian of the  
19 child information on the coverage available  
20 under this title, including benefits and  
21 cost-sharing; and

22 “(iii) shall provide at least one oppor-  
23 tunity per fiscal year for beneficiaries to  
24 switch coverage under this title from cov-  
25 erage described in subparagraph (A) to the

1 coverage that is otherwise made available  
2 under this title.

3 “(E) INFORMATION ON COVERAGE OP-  
4 TIONS.—A State child health plan shall—

5 “(i) describe how the State will notify  
6 potential beneficiaries of coverage de-  
7 scribed in subparagraph (A);

8 “(ii) provide such notification in writ-  
9 ing at least during the initial application  
10 for enrollment under this title and during  
11 redeterminations of eligibility if the indi-  
12 vidual was enrolled before October 1, 2009;  
13 and

14 “(iii) post a description of these cov-  
15 erage options on any official website that  
16 may be established by the State in connec-  
17 tion with the plan.

18 “(F) RULE OF CONSTRUCTION.—Nothing  
19 in this section is to be construed to prohibit a  
20 State from—

21 “(i) establishing limits on beneficiary  
22 cost-sharing under such alternative cov-  
23 erage;

1           “(ii) paying all or part of a bene-  
2           ficiary’s cost-sharing requirements under  
3           such coverage;

4           “(iii) paying less than the full cost of  
5           a child’s share of the premium under such  
6           coverage, insofar as the premium for such  
7           coverage exceeds the limitation established  
8           by the State under subparagraph (C);

9           “(iv) using State funds to pay for  
10          benefits above the Federal upper limit es-  
11          tablished under subparagraph (C); or

12          “(v) providing any guidance or infor-  
13          mation it deems appropriate in order to  
14          help beneficiaries make an informed deci-  
15          sion regarding the option to enroll in cov-  
16          erage described in subparagraph (A).”.

17 **SEC. 303. APPLICATION TO MEDICAID.**

18         In accordance with rules established by the Secretary  
19         of Health and Human Services, the requirements imposed  
20         under a State child health plan under title XXI of the  
21         Social Security Act under the amendments made by the  
22         preceding sections of this subtitle shall apply in the same  
23         manner to a State plan under title XIX of such Act, except  
24         that—

1           (1) such requirements shall not apply to indi-  
2           viduals whose eligibility for medical assistance under  
3           such title is based on being aged, blind, or disabled  
4           or to individuals with a category of individuals de-  
5           scribed in section 1937(a)(2)(B) of such Act; and

6           (2) the national per capita expenditures shall be  
7           determined based on a benchmark coverage de-  
8           scribed in section 1937(b)(1) of such Act but with-  
9           out regard to expenditures for individuals described  
10          in paragraph (1) or for nursing facility services and  
11          other long-term care services (as determined by the  
12          Secretary).

13 **SEC. 304. EXPANSION OF HEALTH OPPORTUNITY ACCOUNT**  
14 **PROGRAM.**

15         (a) IN GENERAL.—Section 613 of the Children’s  
16         Health Insurance Program Reauthorization Act of 2009  
17         (Public Law 111–3) is repealed.

18         (b) EXPANSION.—Section 1938(a)(2) of the Social  
19         Security Act (42 U.S.C. 1396u–8(a)(2)) is amended—

20           (1) in subparagraph (A) by striking everything  
21           following the first sentence; and

22           (2) by striking subparagraph (B).

1 **SEC. 305. VERIFICATION REQUIREMENTS TO PREVENT IL-**  
 2 **LEGAL ALIENS FROM RECEIVING MEDICAID**  
 3 **BENEFITS.**

4 Section 1904 of the Social Security Act (42 U.S.C.  
 5 1396e) is amended—

6 (1) by striking “If the Secretary” and inserting  
 7 the following:

8 “(a) **OVERSIGHT.**—If the Secretary”; and

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

11 “(b) **PREVENTING ILLEGAL ALIENS FROM RECEIV-**  
 12 **ING MEDICAID BENEFITS.**—

13 “(1) **VERIFICATION AS CONDITION ON FUND-**  
 14 **ING.**—Notwithstanding any other provision of law,  
 15 subject to paragraphs (3) and (4), the Secretary  
 16 shall not provide funding under 1903(a) for medical  
 17 assistance provided to an individual (other than  
 18 emergency services unless such individual has been  
 19 determined to be eligible for medical assistance  
 20 under this title on the basis of—

21 “(A) United States citizenship or nation-  
 22 ality through the verification process described  
 23 in section 1903(x); or

24 “(B) qualified alien status through the im-  
 25 migration status verification system described  
 26 in section 1137(d).

1 “(2) **RULE OF CONSTRUCTION.**—Nothing in the  
 2 America’s Affordable Health Choices Act of 2009 or  
 3 the amendments made by that Act shall be con-  
 4 structed as exempting any individual from the eligi-  
 5 bility verification requirements specified in para-  
 6 graph (1).

7 “(3) **NO APPLICATION TO DSIL.**—Paragraph (1)  
 8 shall not apply to or affect the payments described  
 9 in section 1923(f) (relating to disproportionate share  
 10 hospital payments).

11 “(4) **NO APPLICATION TO EMERGENCY MEDICAL**  
 12 **SERVICES.**—Paragraph (1) shall not apply to emer-  
 13 gency medical services described in section 1903(f),  
 14 regardless of the status of the individual for whom  
 15 such services are provided.

16 “(5) **NO IMPACT ON EMTALA.**—Nothing in this  
 17 subsection shall be construed as affecting the appli-  
 18 cation of the requirements of section 1867.”

19 **Subtitle B—Community Health**  
 20 **Centers**

21 **SEC. 311. INCREASED FUNDING.**

22 Section 330 of the Public Health Service Act (42  
 23 U.S.C. 254b) is amended—

24 (1) in subsection (r)(1)—

1 (A) in subparagraph (D), by striking  
2 “and” at the end;

3 (B) in subparagraph (E), by striking the  
4 period at the end and inserting “; and”; and

5 (C) by inserting at the end the following:

6 “(F) Such sums as may be necessary for  
7 each of fiscal years 2013 and 2019.”; and

8 (2) by inserting after subsection (r) the fol-  
9 lowing:

10 “(s) ADDITIONAL FUNDING.—For the purpose of  
11 carrying out this section, in addition to any other amounts  
12 authorized to be appropriated for such purpose, there are  
13 authorized to be appropriated, out of any monies in the  
14 Public Health Investment Fund, the following:

15 “(1) For fiscal year 2010, \$1,000,000,000.

16 “(2) For fiscal year 2011, \$1,500,000,000.

17 “(3) For fiscal year 2012, \$2,500,000,000.

18 “(4) For fiscal year 2013, \$3,000,000,000.

19 “(5) For fiscal year 2014, \$4,000,000,000.

20 “(6) For fiscal year 2015, \$4,400,000,000.

21 “(7) For fiscal year 2016, \$4,800,000,000.

22 “(8) For fiscal year 2017, \$5,300,000,000.

23 “(9) For fiscal year 2018, \$5,900,000,000.

24 “(10) For fiscal year 2019, \$6,400,000,000.”

## 1 **TITLE IV—EXPANDING HEALTH** 2 **SAVINGS ACCOUNTS**

### 3 **SEC. 401. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-** 4 **TRIBUTIONS TO THE SAME HSA ACCOUNT.**

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

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

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

14 “(ii) the spouse is not an account ben-  
15 eficiary of a health savings account as of  
16 the close of such year,  
17 the additional contribution amount shall be 200  
18 percent of the amount otherwise determined  
19 under subparagraph (B).”

20 (b) EFFECTIVE DATE.—The amendment made by  
21 this section shall apply to taxable years beginning after  
22 the date of the enactment of this Act.

### 23 **SEC. 402. PROVISIONS RELATING TO MEDICARE.**

24 (a) INDIVIDUALS OVER AGE 65 ONLY ENROLLED IN  
25 MEDICARE PART A.—Section 223(b)(7) of the Internal

1 Revenue Code of 1986 (relating to contribution limitation  
2 on Medicare eligible individuals) is amended by adding at  
3 the end the following new sentence: "This paragraph shall  
4 not apply to any individual during any period the individ-  
5 ual's only entitlement to such benefits is an entitlement  
6 to hospital insurance benefits under part A of title XVIII  
7 of such Act pursuant to an enrollment for such hospital  
8 insurance benefits under section 226(a)(1) of such Act."

9 (b) **MEDICARE BENEFICIARIES PARTICIPATING IN**  
10 **MEDICARE ADVANTAGE MSA MAY CONTRIBUTE THEIR**  
11 **OWN MONEY TO THEIR MSA.**—Subsection (b) of section  
12 138 of such Code is amended by striking paragraph (2)  
13 and by redesignating paragraphs (3) and (4) as para-  
14 graphs (2) and (3), respectively.

15 (c) **EFFECTIVE DATE.**—The amendments made by  
16 this section shall apply to taxable years beginning after  
17 the date of the enactment of this Act.

18 **SEC. 403. INDIVIDUALS ELIGIBLE FOR VETERANS BENE-**  
19 **FITS FOR A SERVICE-CONNECTED DIS-**  
20 **ABILITY.**

21 (a) **IN GENERAL.**—Section 223(c)(1) of the Internal  
22 Revenue Code of 1986 (defining eligible individual) is  
23 amended by adding at the end the following new subpara-  
24 graph:

1 "(C) **SPECIAL RULE FOR INDIVIDUALS ELI-**  
2 **GIBLE FOR CERTAIN VETERANS BENEFITS.**—  
3 For purposes of subparagraph (A)(ii), an indi-  
4 vidual shall not be treated as covered under a  
5 health plan described in such subparagraph  
6 merely because the individual receives periodic  
7 hospital care or medical services for a service-  
8 connected disability under any law administered  
9 by the Secretary of Veterans Affairs but only if  
10 the individual is not eligible to receive such care  
11 or services for any condition other than a serv-  
12 ice-connected disability."

13 (b) **EFFECTIVE DATE.**—The amendments made by  
14 this section shall apply to taxable years beginning after  
15 the date of the enactment of this Act.

16 **SEC. 404. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH**  
17 **SERVICE ASSISTANCE.**

18 (a) **IN GENERAL.**—Section 223(c)(1) of the Internal  
19 Revenue Code of 1986, as amended by this Act, is amend-  
20 ed by adding at the end the following new subparagraph:

21 "(D) **SPECIAL RULE FOR INDIVIDUALS ELI-**  
22 **IGIBLE FOR ASSISTANCE UNDER INDIAN**  
23 **HEALTH SERVICE PROGRAMS.**—For purposes of  
24 subparagraph (A)(ii), an individual shall not be  
25 treated as covered under a health plan de-

1 scribed in such subparagraph merely because  
 2 the individual receives hospital care or medical  
 3 services under a medical care program of the  
 4 Indian Health Service or of a tribal organiza-  
 5 tion.”.

6 (b) EFFECTIVE DATE.—The amendment made by  
 7 this section shall apply to taxable years beginning after  
 8 the date of the enactment of this Act.

9 **SEC. 405. FSA AND HRA TERMINATION TO FUND HSAS.**

10 (a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA  
 11 PARTICIPANTS.—Section 223(c)(1)(B) of the Internal  
 12 Revenue Code of 1986 is amended—

13 (1) by striking “and” at the end of clause (ii),

14 (2) by striking the period at the end of clause

15 (iii) and inserting “, and”, and

16 (3) by inserting after clause (iii) the following  
 17 new clause:

18 “(iv) coverage under a health flexible  
 19 spending arrangement or a health reim-  
 20 bursement arrangement in the plan year a  
 21 qualified HSA distribution as described in  
 22 section 106(e) is made on behalf of the in-  
 23 dividual if after the qualified HSA dis-  
 24 tribution is made and for the remaining  
 25 duration of the plan year, the coverage

1 provided under the health flexible spending  
 2 arrangement or health reimbursement ar-  
 3 rangement is converted to—

4 “(I) coverage that does not pay  
 5 or reimburse any medical expense in-  
 6 curred before the minimum annual de-  
 7 ductible under section 223(c)(2)(A)(i)  
 8 (prorated for the period occurring  
 9 after the qualified HSA distribution is  
 10 made) is satisfied,

11 “(II) coverage that, after the  
 12 qualified HSA distribution is made,  
 13 does not pay or reimburse any med-  
 14 ical expense incurred after the quali-  
 15 fied HSA distribution is made other  
 16 than preventive care as defined in sec-  
 17 tion 223(c)(2)(3),

18 “(III) coverage that, after the  
 19 qualified HSA distribution is made,  
 20 pays or reimburses benefits for cov-  
 21 erage described in section  
 22 223(c)(1)(B)(ii) (but not through in-  
 23 surance or for long-term care serv-  
 24 ices),

1 “(IV) coverage that, after the  
2 qualified HSA distribution is made,  
3 pays or reimburses benefits for per-  
4 mitted insurance as defined in section  
5 223(c)(1)(B)(i) or coverage described  
6 in section 223(c)(1)(B)(ii) (but not  
7 for long-term care services),

8 “(V) coverage that, after the  
9 qualified HSA distribution is made,  
10 pays or reimburses only those medical  
11 expenses incurred after an individual’s  
12 retirement (and no expenses incurred  
13 before retirement), or

14 “(VI) coverage that, after the  
15 qualified HSA distribution is made, is  
16 suspended, pursuant to an election  
17 made on or before the date the indi-  
18 vidual elects a qualified HSA distribu-  
19 tion or, if later, on the date of the in-  
20 dividual enrolls in a high deductible  
21 health plan (as defined in section  
22 223(c)(2)), that does not pay or reim-  
23 burse, at any time, any medical ex-  
24 pense incurred during the suspension

1 period except as defined in subclauses  
2 (I) through (V) above.”.

3 (b) QUALIFIED HSA DISTRIBUTION SHALL NOT AF-  
4 FECT FLEXIBLE SPENDING ARRANGEMENT.—Section  
5 106(e)(1) of such Code is amended to read as follows:

6 “(1) IN GENERAL.—A plan shall not fail to be  
7 treated as a health flexible spending arrangement  
8 under this section, section 105, or section 125, or as  
9 a health reimbursement arrangement under this sec-  
10 tion or section 105, merely because such plan pro-  
11 vides for a qualified HSA distribution.”.

12 (c) FSA BALANCES AT YEAR END SHALL NOT FOR-  
13 FEIT.—Section 125(d)(2) of such Code is amended by  
14 adding at the end the following new subparagraph:

15 “(E) EXCEPTION FOR QUALIFIED HSA DIS-  
16 TRIBUTIONS.—Subparagraph (A) shall not  
17 apply to the extent that there is an amount re-  
18 maining in a health flexible spending account at  
19 the end of a plan year that an individual elects  
20 to contribute to a health savings account pursu-  
21 ant to a qualified HSA distribution (as defined  
22 in section 106(e)(2)).”.

23 (d) SIMPLIFICATION OF LIMITATIONS ON FSA AND  
24 HRA ROLLOVERS.—Section 106(e)(2) of such Code (re-

1 lating to qualified HSA distribution) is amended to read  
2 as follows:

3 “(2) QUALIFIED HSA DISTRIBUTION.—

4 “(A) IN GENERAL.—The term ‘qualified  
5 HSA distribution’ means a distribution from a  
6 health flexible spending arrangement or health  
7 reimbursement arrangement to the extent that  
8 such distribution does not exceed the lesser  
9 of—

10 “(i) the balance in such arrangement  
11 as of the date of such distribution, or

12 “(ii) the amount determined under  
13 subparagraph (B).

14 Such term shall not include more than 1 dis-  
15 tribution with respect to any arrangement.

16 “(B) DOLLAR LIMITATIONS.—

17 “(i) DISTRIBUTIONS FROM A HEALTH  
18 FLEXIBLE SPENDING ARRANGEMENT.—A  
19 qualified HSA distribution from a health  
20 flexible spending arrangement shall not ex-  
21 ceed the applicable amount.

22 “(ii) DISTRIBUTIONS FROM A HEALTH  
23 REIMBURSEMENT ARRANGEMENT.—A  
24 qualified HSA distribution from a health

1 reimbursement arrangement shall not ex-  
2 ceed—

3 “(I) the applicable amount di-  
4 vided by 12, multiplied by

5 “(II) the number of months dur-  
6 ing which the individual is a partici-  
7 pant in the health reimbursement ar-  
8 rangement.

9 “(iii) APPLICABLE AMOUNT.—For  
10 purposes of this subparagraph, the applica-  
11 ble amount is—

12 “(I) \$2,250 in the case of an eli-  
13 gible individual who has self-only cov-  
14 erage under a high deductible health  
15 plan at the time of such distribution,  
16 and

17 “(II) \$4,500 in the case of an eli-  
18 gible individual who has family cov-  
19 erage under a high deductible health  
20 plan at the time of such distribu-  
21 tion.”.

22 (e) ELIMINATION OF ADDITIONAL TAX FOR FAILURE  
23 TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COV-  
24 ERAGE.—Section 106(e) of such Code is amended—

1 (1) by striking paragraph (3) and redesignating  
2 paragraphs (4) and (5) as paragraphs (3) and (4),  
3 respectively, and

4 (2) by striking subparagraph (A) of paragraph  
5 (3), as so redesignated, and redesignating subpara-  
6 graphs (B) and (C) of such paragraph as subpara-  
7 graphs (A) and (B) thereof, respectively.

8 (f) LIMITED PURPOSE FSAS AND HRAS.—Section  
9 106(e) of such Code, as amended by this section, is  
10 amended by adding at the end the following new para-  
11 graph:

12 “(5) LIMITED PURPOSE FSAS AND HRAS.—A  
13 plan shall not fail to be a health flexible spending  
14 arrangement or health reimbursement arrangement  
15 under this section or section 105 merely because the  
16 plan converts coverage for individuals who enroll in  
17 a high deductible health plan described in section  
18 223(c)(2) to coverage described in section  
19 223(c)(1)(B)(iv). Coverage for such individuals may  
20 be converted as of the date of enrollment in the high  
21 deductible health plan, without regard to the period  
22 of coverage under the health flexible spending ar-  
23 rangement or health reimbursement arrangement,  
24 and without requiring any change in coverage to in-

1 dividuals who do not enroll in a high deductible  
2 health plan.”.

3 (g) DISTRIBUTION AMOUNTS ADJUSTED FOR COST-  
4 OF-LIVING.—Section 106(e) of such Code, as amended by  
5 this section, is amended by adding at the end the following  
6 new paragraph:

7 “(6) COST-OF-LIVING ADJUSTMENT.—

8 “(A) IN GENERAL.—In the case of any  
9 taxable year beginning after December 31,  
10 2010, each of the dollar amounts in paragraph  
11 (2)(B)(iii) shall be increased by an amount  
12 equal to such dollar amount, multiplied by the  
13 cost-of-living adjustment determined under sec-  
14 tion 1(f)(3) for the calendar year in which such  
15 taxable year begins by substituting ‘calendar  
16 year 2009’ for ‘calendar year 1992’ in subpara-  
17 graph (B) thereof.

18 “(B) ROUNDING.—If any increase under  
19 paragraph (1) is not a multiple of \$50, such in-  
20 crease shall be rounded to the nearest multiple  
21 of \$50.”.

22 (h) DISCLAIMER OF DISQUALIFYING COVERAGE.—  
23 Section 223(c)(1)(B) of such Code, as amended by this  
24 section, is amended—

25 (1) by striking “and” at the end of clause (iii),

1 (2) by striking the period at the end of clause  
2 (iv) and inserting “. and”, and

3 (3) by inserting after clause (iv) the following  
4 new clause:

5 “(v) any coverage (including prospec-  
6 tive coverage) under a health plan that is  
7 not a high deductible health plan which is  
8 disclaimed in writing, at the time of the  
9 creation or organization of the health sav-  
10 ings account, including by execution of a  
11 trust described in subsection (d)(1)  
12 through a governing instrument that in-  
13 cludes such a disclaimer, or by acceptance  
14 of an amendment to such a trust that in-  
15 cludes such a disclaimer.”.

16 (i) **EFFECTIVE DATE.**—The amendments made by  
17 this section shall apply to taxable years beginning after  
18 the date of the enactment of this Act.

19 **SEC. 406. PURCHASE OF HEALTH INSURANCE FROM HSA**  
20 **ACCOUNT.**

21 (a) **IN GENERAL.**—Paragraph (2) of section 223(d)  
22 of the Internal Revenue Code of 1986 (defining qualified  
23 medical expenses) is amended—

24 (1) by striking subparagraphs (B) and (C),

1 (2) by inserting “ and including payment for in-  
2 surance)” after “section 213(d)”.

3 (b) **EFFECTIVE DATE.**—The amendments made by  
4 this section shall apply to taxable years beginning after  
5 the date of the enactment of this Act.

6 **SEC. 407. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**  
7 **INCURRED BEFORE ESTABLISHMENT OF AC-**  
8 **COUNT.**

9 (a) **IN GENERAL.**—Paragraph (2) of section 223(d)  
10 of the Internal Revenue Code of 1986, as amended by this  
11 Act, is amended by adding at the end the following new  
12 subparagraph:

13 “(B) **CERTAIN MEDICAL EXPENSES IN-**  
14 **CURRED BEFORE ESTABLISHMENT OF ACCOUNT**  
15 **TREATED AS QUALIFIED.**—An expense shall not  
16 fail to be treated as a qualified medical expense  
17 solely because such expense was incurred before  
18 the establishment of the health savings account  
19 if such expense was incurred—

20 “(i) during either—

21 “(I) the taxable year in which the  
22 health savings account was estab-  
23 lished, or

24 “(II) the preceding taxable year  
25 in the case of a health savings ac-

1 count established after the taxable  
2 year in which such expense was in-  
3 curred but before the time prescribed  
4 by law for filing the return for such  
5 taxable year (not including extensions  
6 thereof), and

7 “(ii) for medical care of an individual  
8 during a period that such individual was  
9 covered by a high deductible health plan  
10 and met the requirements of subsection  
11 (c)(1)(A)(ii) (after application of sub-  
12 section (c)(1)(B)).”.

13 (b) EFFECTIVE DATE.—The amendment made by  
14 this section shall apply to health savings accounts estab-  
15 lished during taxable years beginning after the date of the  
16 enactment of this Act.

17 **SEC. 408. PREVENTIVE CARE PRESCRIPTION DRUG CLARI-**  
18 **FICATION.**

19 (a) CLARIFY USE OF DRUGS IN PREVENTIVE  
20 CARE.—Subparagraph (C) of section 223(c)(2) of the In-  
21 ternal Revenue Code of 1986 is amended by adding at the  
22 end the following: “Preventive care shall include prescrip-  
23 tion and over-the-counter drugs and medicines which have  
24 the primary purpose of preventing the onset of, further

1 deterioration from, or complications associated with  
2 chronic conditions, illnesses, or diseases.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 this section shall apply to taxable years beginning after  
5 the date of the enactment of this Act.

6 **SEC. 409. QUALIFIED MEDICAL EXPENSES.**

7 (a) CERTAIN EXERCISE EQUIPMENT AND PHYSICAL  
8 FITNESS PROGRAMS TREATED AS MEDICAL CARE.—

9 (1) IN GENERAL.—Subsection (d) of section  
10 213 of the Internal Revenue Code of 1986 is amend-  
11 ed by adding at the end the following new para-  
12 graph:

13 “(12) EXERCISE EQUIPMENT AND PHYSICAL  
14 FITNESS PROGRAMS.—

15 “(A) IN GENERAL.—The term ‘medical  
16 care’ shall include amounts paid—

17 “(i) to purchase or use equipment  
18 used in a program (including a self-di-  
19 rected program) of physical exercise,

20 “(ii) to participate, or receive instruc-  
21 tion, in a program of physical exercise, and

22 “(iii) for membership dues in a fitness  
23 club the primary purpose of which is to  
24 provide access to equipment and facilities  
25 for physical exercise.

1           “(B) LIMITATION.—Amounts treated as  
2           medical care under subparagraph (A) shall not  
3           exceed \$1,000 with respect to any individual for  
4           any taxable year.”.

5           (2) EFFECTIVE DATE.—The amendment made  
6           by this subsection shall apply to taxable years begin-  
7           ning after the date of the enactment of this Act.

8           (b) CERTAIN NUTRITIONAL AND DIETARY SUPPLE-  
9           MENTS TO BE TREATED AS MEDICAL CARE.—

10          (1) IN GENERAL.—Subsection (d) of section  
11          213 of such Code, as amended by subsection (a), is  
12          amended by adding at the end the following new  
13          paragraph:

14          “(13) NUTRITIONAL AND DIETARY SUPPLE-  
15          MENTS.—

16                 “(A) IN GENERAL.—The term ‘medical  
17                 care’ shall include amounts paid to purchase  
18                 herbs, vitamins, minerals, homeopathic reme-  
19                 dies, meal replacement products, and other di-  
20                 etary and nutritional supplements.

21                 “(B) LIMITATION.—Amounts treated as  
22                 medical care under subparagraph (A) shall not  
23                 exceed \$1,000 with respect to any individual for  
24                 any taxable year.

1           “(C) MEAL REPLACEMENT PRODUCT.—  
2           For purposes of this paragraph, the term ‘meal  
3           replacement product’ means any product that—

4                 “(i) is permitted to bear labeling mak-  
5                 ing a claim described in section 403(r)(3)  
6                 of the Federal Food, Drug, and Cosmetic  
7                 Act, and

8                 “(ii) is permitted to claim under such  
9                 section that such product is low in fat and  
10                is a good source of protein, fiber, and mul-  
11                tiple essential vitamins and minerals.”.

12          (2) EFFECTIVE DATE.—The amendment made  
13          by this subsection shall apply to taxable years begin-  
14          ning after the date of the enactment of this Act.

## 15           **TITLE V—MEDICAL LIABILITY** 16                                 **REFORM**

### 17           **Subtitle A—Medical Liability**

#### 18           **SEC. 501. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

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

1 after the date of manifestation of injury unless tolled for  
2 any of the following—

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

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

18 **SEC. 502. COMPENSATING PATIENT INJURY.**

19 (a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL**  
20 **ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any  
21 health care lawsuit, nothing in this subtitle shall limit a  
22 claimant's recovery of the full amount of the available eco-  
23 nomic damages, notwithstanding the limitation in sub-  
24 section (b).

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

7 (c) **NO DISCOUNT OF AWARD FOR NONECONOMIC**  
8 **DAMAGES.**—For purposes of applying the limitation in  
9 subsection (b), future noneconomic damages shall not be  
10 discounted to present value. The jury shall not be in-  
11 formed about the maximum award for noneconomic dam-  
12 ages. An award for noneconomic damages in excess of  
13 \$250,000 shall be reduced either before the entry of judg-  
14 ment, or by amendment of the judgment after entry of  
15 judgment, and such reduction shall be made before ac-  
16 counting for any other reduction in damages required by  
17 law. If separate awards are rendered for past and future  
18 noneconomic damages and the combined awards exceed  
19 \$250,000, the future noneconomic damages shall be re-  
20 duced first.

21 (d) **FAIR SHARE RULE.**—In any health care lawsuit,  
22 each party shall be liable for that party's several share  
23 of any damages only and not for the share of any other  
24 person. Each party shall be liable only for the amount of  
25 damages allocated to such party in direct proportion to

1 such party's percentage of responsibility. Whenever a  
 2 judgment of liability is rendered as to any party, a sepa-  
 3 rate judgment shall be rendered against each such party  
 4 for the amount allocated to such party. For purposes of  
 5 this section, the trier of fact shall determine the propor-  
 6 tion of responsibility of each party for the claimant's  
 7 harm.

8 **SEC. 503. MAXIMIZING PATIENT RECOVERY.**

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

24 (1) 40 percent of the first \$50,000 recovered by  
 25 the claimant(s).

1 (2) 33⅓ percent of the next \$50,000 recovered  
 2 by the claimant(s).

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

5 (4) 15 percent of any amount by which the re-  
 6 covery by the claimant(s) is in excess of \$600,000.

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

16 **SEC. 504. ADDITIONAL HEALTH BENEFITS.**

17 In any health care lawsuit involving injury or wrong-  
 18 ful death, any party may introduce evidence of collateral  
 19 source benefits. If a party elects to introduce such evi-  
 20 dence, any opposing party may introduce evidence of any  
 21 amount paid or contributed or reasonably likely to be paid  
 22 or contributed in the future by or on behalf of the oppos-  
 23 ing party to secure the right to such collateral source bene-  
 24 fits. No provider of collateral source benefits shall recover  
 25 any amount against the claimant or receive any lien or

1 credit against the claimant's recovery or be equitably or  
2 legally subrogated to the right of the claimant in a health  
3 care lawsuit involving injury or wrongful death. This sec-  
4 tion shall apply to any health care lawsuit that is settled  
5 as well as a health care lawsuit that is resolved by a fact  
6 finder. This section shall not apply to section 1862(b) (42  
7 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.  
8 1396a(a)(25)) of the Social Security Act.

9 **SEC. 505. PUNITIVE DAMAGES.**

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

1 hearing, after weighing the evidence, that the claimant has  
2 established by a substantial probability that the claimant  
3 will prevail on the claim for punitive damages. At the re-  
4 quest of any party in a health care lawsuit, the trier of  
5 fact shall consider in a separate proceeding—

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

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

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

15 (b) DETERMINING AMOUNT OF PUNITIVE DAM-  
16 AGES.—

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

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

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

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

3 (D) the number of products sold or med-  
4 ical procedures rendered for compensation, as  
5 the case may be, by such party, of the kind  
6 causing the harm complained of by the claim-  
7 ant;

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

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

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

20 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT  
21 COMPLY WITH FDA STANDARDS.—

22 (1) IN GENERAL.—

23 (A) No punitive damages may be awarded  
24 against the manufacturer or distributor of a  
25 medical product, or a supplier of any compo-

1 nent or raw material of such medical product,  
2 based on a claim that such product caused the  
3 claimant's harm where—

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

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

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

1 cable Food and Drug Administration stat-  
2 utes and regulations.

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

10 (2) LIABILITY OF HEALTH CARE PROVIDERS.—

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

23 (3) PACKAGING.—In a health care lawsuit for  
24 harm which is alleged to relate to the adequacy of  
25 the packaging or labeling of a drug which is required

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

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

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

22 (B) a person made an illegal payment to  
23 an official of the Food and Drug Administra-  
24 tion for the purpose of either securing or main-

1 taining approval, clearance, or licensure of such  
2 medical product.

3 **SEC. 506. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**  
4 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**  
5 **SUITS.**

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

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

20 **SEC. 507. DEFINITIONS.**

21 In this subtitle:

22 (1) **ALTERNATIVE DISPUTE RESOLUTION SYS-**  
23 **TEM; ADR.**—The term “alternative dispute resolution  
24 system” or “ADR” means a system that provides  
25 for the resolution of health care lawsuits in a man-

1 ner other than through a civil action brought in a  
2 State or Federal court.

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

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

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

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

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

6 (D) any other publicly or privately funded  
7 program.

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

1 economic damages, as such terms are defined in this  
2 section.

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

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

16 (7) HEALTH CARE LAWSUIT.—The term  
17 “health care lawsuit” means any health care liability  
18 claim concerning the provision of health care goods  
19 or services or any medical product affecting inter-  
20 state commerce, or any health care liability action  
21 concerning the provision of health care goods or  
22 services or any medical product affecting interstate  
23 commerce, brought in a State or Federal court or  
24 pursuant to an alternative dispute resolution system,  
25 against a health care provider, a health care organi-

1 zation, or the manufacturer, distributor, supplier,  
2 marketer, promoter, or seller of a medical product,  
3 regardless of the theory of liability on which the  
4 claim is based, or the number of claimants, plain-  
5 tiffs, defendants, or other parties, or the number of  
6 claims or causes of action, in which the claimant al-  
7 leges a health care liability claim. Such term does  
8 not include a claim or action which is based on  
9 criminal liability; which seeks civil fines or penalties  
10 paid to Federal, State, or local government; or which  
11 is grounded in antitrust.

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

23 (9) HEALTH CARE LIABILITY CLAIM.—The  
24 term “health care liability claim” means a demand  
25 by any person, whether or not pursuant to ADR,

1 against a health care provider, health care organiza-  
2 tion, or the manufacturer, distributor, supplier, mar-  
3 keter, promoter, or seller of a medical product, in-  
4 cluding, but not limited to, third-party claims, cross-  
5 claims, counter-claims, or contribution claims, which  
6 are based upon the provision of, use of, or payment  
7 for (or the failure to provide, use, or pay for) health  
8 care services or medical products, regardless of the  
9 theory of liability on which the claim is based, or the  
10 number of plaintiffs, defendants, or other parties, or  
11 the number of causes of action.

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

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

1 (12) HEALTH CARE GOODS OR SERVICES.—The  
2 term “health care goods or services” means any  
3 goods or services provided by a health care organiza-  
4 tion, provider, or by any individual working under  
5 the supervision of a health care provider, that relates  
6 to the diagnosis, prevention, or treatment of any  
7 human disease or impairment, or the assessment or  
8 care of the health of human beings.

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

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

24 (15) NONECONOMIC DAMAGES.—The term  
25 “noneconomic damages” means damages for phys-

1 ical and emotional pain, suffering, inconvenience,  
2 physical impairment, mental anguish, disfigurement,  
3 loss of enjoyment of life, loss of society and compan-  
4 ionship, loss of consortium (other than loss of do-  
5 mestic service), hedonic damages, injury to reputa-  
6 tion, and all other nonpecuniary losses of any kind  
7 or nature.

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

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

24 (18) STATE.—The term “State” means each of  
25 the several States, the District of Columbia, the

1 Commonwealth of Puerto Rico, the Virgin Islands,  
 2 Guam, American Samoa, the Northern Mariana Is-  
 3 lands, the Trust Territory of the Pacific Islands, and  
 4 any other territory or possession of the United  
 5 States, or any political subdivision thereof.

6 **SEC. 508. EFFECT ON OTHER LAWS.**

7 (a) **VACCINE INJURY.**—

8 (1) To the extent that title XXI of the Public  
 9 Health Service Act (42 U.S.C. 300aa-1 et seq.) es-  
 10 tablishes a Federal rule of law applicable to a civil  
 11 action brought for a vaccine-related injury or  
 12 death—

13 (A) this subtitle does not affect the appli-  
 14 cation of the rule of law to such an action; and

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

18 (2) If there is an aspect of a civil action  
 19 brought for a vaccine-related injury or death to  
 20 which a Federal rule of law under title XXI of the  
 21 Public Health Service Act (42 U.S.C. 300aa-1 et  
 22 seq.) does not apply, then this subtitle or otherwise  
 23 applicable law (as determined under this subtitle)  
 24 will apply to such aspect of such action.

1 (b) **OTHER FEDERAL LAW.**—Except as provided in  
 2 this section, nothing in this subtitle shall be deemed to  
 3 affect any defense available to a defendant in a health care  
 4 lawsuit or action under any other provision of Federal law.

5 **SEC. 509. STATE FLEXIBILITY AND PROTECTION OF**  
 6 **STATES' RIGHTS.**

7 (a) **HEALTH CARE LAWSUITS.**—The provisions gov-  
 8 erning health care lawsuits set forth in this subtitle pre-  
 9 empt, subject to subsections (b) and (c), State law to the  
 10 extent that State law prevents the application of any pro-  
 11 visions of law established by or under this subtitle. The  
 12 provisions governing health care lawsuits set forth in this  
 13 subtitle supersede chapter 171 of title 28, United States  
 14 Code, to the extent that such chapter—

15 (1) provides for a greater amount of damages  
 16 or contingent fees, a longer period in which a health  
 17 care lawsuit may be commenced, or a reduced appli-  
 18 cability or scope of periodic payment of future dam-  
 19 ages, than provided in this subtitle; or

20 (2) prohibits the introduction of evidence re-  
 21 garding collateral source benefits, or mandates or  
 22 permits subrogation or a lien on collateral source  
 23 benefits.

24 (b) **PROTECTION OF STATES' RIGHTS AND OTHER**  
 25 **LAWS.**—(1) Any issue that is not governed by any provi-

1 sion of law established by or under this subtitle (including  
2 State standards of negligence) shall be governed by other-  
3 wise applicable State or Federal law.

4 (2) This subtitle shall not preempt or supersede any  
5 State or Federal law that imposes greater procedural or  
6 substantive protections for health care providers and  
7 health care organizations from liability, loss, or damages  
8 than those provided by this subtitle or create a cause of  
9 action.

10 (c) STATE FLEXIBILITY.—No provision of this sub-  
11 title shall be construed to preempt—

12 (1) any State law (whether effective before, on,  
13 or after the date of the enactment of this Act) that  
14 specifies a particular monetary amount of compen-  
15 satory or punitive damages (or the total amount of  
16 damages) that may be awarded in a health care law-  
17 suit, regardless of whether such monetary amount is  
18 greater or lesser than is provided for under this Act,  
19 notwithstanding section 502(a); or

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

23 **SEC. 510. APPLICABILITY; EFFECTIVE DATE.**

24 This subtitle shall apply to any health care lawsuit  
25 brought in a Federal or State court, or subject to an alter-

1 native dispute resolution system, that is initiated on or  
2 after the date of the enactment of this Act, except that  
3 any health care lawsuit arising from an injury occurring  
4 prior to the date of the enactment of this Act shall be  
5 governed by the applicable statute of limitations provisions  
6 in effect at the time the injury occurred.

7 **SEC. 511. SENSE OF CONGRESS.**

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

12 **Subtitle B—Liability Protection for**  
13 **Community Health Center Vol-**  
14 **unteers**

15 **SEC. 521. HEALTH CENTERS UNDER PUBLIC HEALTH SERV-**  
16 **ICE ACT; LIABILITY PROTECTIONS FOR VOL-**  
17 **UNTEER PRACTITIONERS.**

18 (a) IN GENERAL.—Section 224 of the Public Health  
19 Service Act (42 U.S.C. 233) is amended—

20 (1) in subsection (g)(1)(A)—

21 (A) in the first sentence, by striking “or  
22 employee” and inserting “employee, or (subject  
23 to subsection (k)(4)) volunteer practitioner”;  
24 and

1 (B) in the second sentence, by inserting  
2 “and subsection (k)(4)” after “subject to para-  
3 graph (5)”; and

4 (2) in each of subsections (g), (i), (j), (k), (l),  
5 and (m)—

6 (A) by striking the term “employee, or  
7 contractor” each place such term appears and  
8 inserting “employee, volunteer practitioner, or  
9 contractor”;

10 (B) by striking the term “employee, and  
11 contractor” each place such term appears and  
12 inserting “employee, volunteer practitioner, and  
13 contractor”;

14 (C) by striking the term “employee, or any  
15 contractor” each place such term appears and  
16 inserting “employee, volunteer practitioner, or  
17 contractor”; and

18 (D) by striking the term “employees, or  
19 contractors” each place such term appears and  
20 inserting “employees, volunteer practitioners, or  
21 contractors”.

22 (b) APPLICABILITY; DEFINITION.—Section 224(k) of  
23 the Public Health Service Act (42 U.S.C. 233(k)) is  
24 amended by adding at the end the following paragraph:

1 “(4)(A) Subsections (g) through (m) apply with re-  
2 spect to volunteer practitioners beginning with the first  
3 fiscal year for which an appropriations Act provides that  
4 amounts in the fund under paragraph (2) are available  
5 with respect to such practitioners.

6 “(B) For purposes of subsections (g) through (m),  
7 the term ‘volunteer practitioner’ means a practitioner who,  
8 with respect to an entity described in subsection (g)(4),  
9 meets the following conditions:

10 “(i) The practitioner is a licensed physician or  
11 a licensed clinical psychologist.

12 “(ii) At the request of such entity, the practi-  
13 tioner provides services to patients of the entity, at  
14 a site at which the entity operates or at a site des-  
15 ignated by the entity. The weekly number of hours  
16 of services provided to the patients by the practi-  
17 tioner is not a factor with respect to meeting condi-  
18 tions under this subparagraph.

19 “(iii) The practitioner does not for the provision  
20 of such services receive any compensation from such  
21 patients, from the entity, or from third-party payors  
22 (including reimbursement under any insurance pol-  
23 icy or health plan, or under any Federal or State  
24 health benefits program).”.

1 **TITLE VI—MISCELLANEOUS**  
 2 **Subtitle A—Provide Adequate**  
 3 **Funding to HHS OIG and HCFAC**  
 4 **SEC. 601. PROVIDE ADEQUATE FUNDING TO HHS OIG AND**  
 5 **HCFAC.**  
 6 (a) HCFAC FUNDING.—Section 1817(k)(3)(A) of  
 7 the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is  
 8 amended—  
 9 (1) in clause (i)—  
 10 (A) in subclause (IV), by striking “2009,  
 11 and 2010” and inserting “and 2009”; and  
 12 (B) by amending subclause (V) to read as  
 13 follows:  
 14 “(V) for each fiscal year after fis-  
 15 cal year 2009, \$300,000,000.”; and  
 16 (2) in clause (ii)—  
 17 (A) in subclause (IX), by striking “2009,  
 18 and 2010” and inserting “and 2009”; and  
 19 (B) in subclause (X), by striking “2010”  
 20 and inserting “2009” and by inserting before  
 21 the period at the end the following: “, plus the  
 22 amount by which the amount made available  
 23 under clause (i)(V) for fiscal year 2010 exceeds  
 24 the amount made available under clause (i)(IV)  
 25 for 2009”.

1 (b) OIG FUNDING.—There are authorized to be ap-  
 2 propriated for each of fiscal years 2010 through 2019  
 3 \$100,000,000 for the Office of the Inspector General of  
 4 the Department of Health and Human Services for fraud  
 5 prevention activities under the Medicare and Medicaid  
 6 programs.  
 7 **Subtitle B—State Transparency**  
 8 **Plan Portal**  
 9 **SEC. 611. PROVIDING INFORMATION ON HEALTH COV-**  
 10 **ERAGE OPTIONS AND HEALTH CARE PRO-**  
 11 **VIDERS.**  
 12 (a) STATE-BASED PORTAL.—A State (by itself or  
 13 jointly with other States) may contract with a private enti-  
 14 ty to establish a Health Plan and Provider Portal website  
 15 (referred to in this section as a “plan portal”) for the pur-  
 16 poses of providing standardized information—  
 17 (1) on health insurance plans that have been  
 18 certified to be available for purchase in that State;  
 19 and  
 20 (2) on price and quality information on health  
 21 care providers (including physicians, hospitals, and  
 22 other health care institutions).  
 23 (b) PILOT PROGRAM.—  
 24 (1) IN GENERAL.—Not later than 90 days after  
 25 the date of the enactment of this Act the Secretary

1 of Health and Human Services shall work with  
2 States to establish no later than 2011, consistent  
3 with this title, a website that will serve as a pilot  
4 program for a national portal for information struc-  
5 tured in a manner so individuals may directly link  
6 to the State plan portal for the State in which they  
7 reside.

8 (2) CONTRACTS WITH STATE.—The Secretary  
9 shall enter into contracts with States, in a number  
10 and distribution determined by the Secretary, to de-  
11 velop State plan portals that follow the applicable  
12 standards and regulations under this section.

13 (3) COMMON STANDARDS FOR PLAN POR-  
14 TALS.—

15 (A) IN GENERAL.—In connection with such  
16 website, the Secretary shall establish standards  
17 for interoperability and consistency for State  
18 plan portals so that individuals can access and  
19 view information in a similar manner on plan  
20 portals of different States. Such standards shall  
21 include standard definitions for health insur-  
22 ance plan benefits so that individuals can accu-  
23 rately compare health insurance plans within  
24 such portals and standards for the inclusion of  
25 information described in subsection (c).

1 (B) CONSULTATION.—The Secretary shall  
2 consult with a group consisting of a balanced  
3 representation of the critical stakeholders (in-  
4 cluding States, health insurance issuers, the  
5 National Association of Insurance Commis-  
6 sioners, qualified health care provider-based en-  
7 tities (including physicians, hospitals, and other  
8 health care institutions), and a standards devel-  
9 opment organization) to develop such stand-  
10 ards.

11 (C) ISSUANCE.—

12 (i) IN GENERAL.—Not later than 6  
13 months after the date of the enactment of  
14 this Act, the Secretary shall issue, by regu-  
15 lation, after notice and opportunity for  
16 public comment, standards that are con-  
17 sistent with the recommendations made by  
18 the group under subparagraph (B).

19 (ii) DISSEMINATION.—The Secretary  
20 shall broadly disseminate the standards so  
21 issued.

22 (D) REVIEW.—One year after the date of  
23 establishment of the pilot program under this  
24 subsection, the Secretary, in consultation with  
25 stakeholder group described in subparagraph

1 (B), shall review the standards established and  
 2 make such changes in such standards as may  
 3 be appropriate.

4 (4) AUTHORIZATION OF APPROPRIATIONS.—

5 There are authorized to be appropriated to the Sec-  
 6 retary such amounts as may be necessary for—

7 (A) the development and operation of the  
 8 national website under this subsection; and

9 (B) contracts with States under paragraph  
 10 (2) to assist in the development and initial op-  
 11 eration of plan portals in accordance with  
 12 standards established under paragraph (3) and  
 13 other applicable provisions of this section.

14 (c) INFORMATION IN PLAN PORTALS.—The stand-  
 15 ards for plan portals under subsection (b)(3) shall include  
 16 the following:

17 (1) HEALTH INSURANCE INFORMATION.—Each  
 18 plan portal shall meet the following requirements  
 19 with respect to information on health insurance  
 20 plans:

21 (A) The plan portal shall present complete  
 22 information on the costs and benefits of health  
 23 insurance plans (including information on  
 24 monthly premium, copayments, deductibles, and  
 25 covered benefits) in a uniform manner that—

1 (i) uses the standard definitions devel-  
 2 oped under subsection (b)(3); and

3 (ii) is designed to allow consumers to  
 4 easily compare such plans.

5 (B) The plan portal shall be available on  
 6 the internet and accessible to all individuals in  
 7 the United States.

8 (C) The plan portal shall allow consumers  
 9 to search and sort data on the health insurance  
 10 plans in the plan portal on criteria such as cov-  
 11 erage of specific benefits (such as coverage of  
 12 disease management services or pediatric care  
 13 services), as well as data available respecting  
 14 quality of plans.

15 (D) The plan portal shall meet all relevant  
 16 State laws and regulations, including laws and  
 17 regulations related to the marketing of insur-  
 18 ance products.

19 (E) Notwithstanding subsection (d)(1), the  
 20 plan portal shall provide information to individ-  
 21 uals who are eligible for the Medicaid program  
 22 under title XIX of the Social Security Act or  
 23 State Children's Health Insurance Program  
 24 under title XXI of such Act by including infor-  
 25 mation on options, eligibility, and how to enroll

1 through providing a link to a website main-  
2 tained with respect to such State programs.

3 (F) The plan portal shall provide support  
4 to individuals who are eligible for tax credits  
5 and deductions under the amendments made by  
6 this Act to enhance such individual's ability to  
7 access such credits and deductions.

8 (G) The plan portal shall allow consumers  
9 to access quality data on providers as made  
10 available through a website once that data is  
11 available.

12 (2) PROVIDER INFORMATION.—Each plan por-  
13 tal shall meet the following requirements with re-  
14 spect to information on health care providers:

15 (A) Identifying and licensure information.

16 (B) Self-pay prices charged, including vari-  
17 ation in such prices.

18 For purposes of subparagraph (B), the term “self-  
19 pay price” means the price charged by a provider to  
20 individuals for items or services where the price is  
21 not established or negotiated through a health care  
22 program or third party.

23 (3) TAX CREDIT AND DEDUCTION INFORMA-  
24 TION.—Each plan portal shall also include informa-

1 tion on tax credits and deductions that may be avail-  
2 able for purpose of qualified health plans.

3 (4) INCLUSION OF QUALITY INFORMATION.—  
4 The Secretary, after collaboration with States and  
5 health care providers (including practicing physi-  
6 cians, hospitals, and other health care institutions),  
7 shall submit to Congress recommendations on how  
8 to include on plan portals information on perform-  
9 ance-based quality measures [obtained under section  
10 612].

11 (d) PROHIBITIONS.—

12 (1) DIRECT ENROLLMENT.—A plan portal may  
13 not directly enroll individuals in health insurance  
14 plans or under a State Medicaid plan or a State  
15 children's health insurance plan.

16 (2) CONFLICTS OF INTEREST.—

17 (A) COMPANIES.—A health insurance  
18 issuer offering a health insurance plan through  
19 a plan portal may not—

20 (i) be the private entity developing  
21 and maintaining a plan portal under this  
22 section; or

23 (ii) have an ownership interest in such  
24 private entity or in the plan portal.

1 (B) INDIVIDUALS.—An individual em-  
 2 ployed by a health insurance issuer offering a  
 3 health insurance plan through a plan portal  
 4 may not serve as a director or officer for—

5 (i) the private entity developing and  
 6 maintaining a plan portal under this sec-  
 7 tion; or

8 (ii) the plan portal.

9 (e) CONSTRUCTION.—Nothing in this section shall be  
 10 construed to prohibit health insurance brokers and agents  
 11 from—

12 (1) utilizing the plan portal for any purpose; or

13 (2) marketing or offering health insurance  
 14 products.

15 (f) STATE DEFINED.—In this section, the term  
 16 “State” has the meaning given such term for purposes of  
 17 title XIX of the Social Security Act.

18 **SEC. 612. ESTABLISHMENT OF PERFORMANCE-BASED**  
 19 **QUALITY MEASURES.**

20 Not later than January 1, 2010, the Secretary of  
 21 Health and Human Services shall submit to Congress a  
 22 proposal for a formalized process for the development of  
 23 performance-based quality measures that could be applied  
 24 to physicians’ services under the Medicare program. Such  
 25 proposal shall be in concert and agreement with the Physi-

1 cian Consortium for Performance Improvement and shall  
 2 only utilize measures agreed upon by each physician spe-  
 3 cialty organization.

4 **Subtitle C—Medicare Accountable**  
 5 **Care Organization Demonstra-**  
 6 **tion Program**

7 **SEC. 621. MEDICARE ACCOUNTABLE CARE ORGANIZATION**  
 8 **DEMONSTRATION PROGRAM.**

9 (a) ESTABLISHMENT.—

10 (1) IN GENERAL.—In order to promote innova-  
 11 tive care coordination and delivery that is cost-effec-  
 12 tive, the Secretary of Health and Human Services  
 13 (in this section referred to as the “Secretary”) shall  
 14 conduct a demonstration program under the Medi-  
 15 care program under which—

16 (A) groups of providers meeting certain  
 17 criteria may work together to manage and co-  
 18 ordinate care for Medicare fee-for-service benec-  
 19 ficiaries through an Accountable Care Organi-  
 20 zation (in this section referred to as an  
 21 “ACO”); and

22 (B) providers in participating ACOs are el-  
 23 igible for bonuses based on performance.

24 (2) MEDICARE FEE-FOR-SERVICE BENEFICIARY  
 25 DEFINED.—In this section, the term “Medicare fee-

1 for-service beneficiary” means an individual who is  
2 enrolled in the original medicare fee-for-service pro-  
3 gram under parts A and B of title XVIII of the So-  
4 cial Security Act and not enrolled in an MA plan  
5 under part C of such title.

6 (b) ELIGIBLE ACOS.—

7 (1) IN GENERAL.—Subject to paragraph (2),  
8 the following provider groups are eligible to partici-  
9 pate as ACOs under the demonstration program  
10 under this section:

11 (A) Physicians in group practice arrange-  
12 ments.

13 (B) Networks of individual physician prac-  
14 tices.

15 (C) Partnerships or joint venture arrange-  
16 ments between hospitals and physicians.

17 (D) Partnerships or joint ventures, which  
18 may include pharmacists providing medication  
19 therapy management.

20 (E) Hospitals employing physicians.

21 (F) Integrated delivery systems.

22 (G) Community-based coalitions of pro-  
23 viders.

24 (2) REQUIREMENTS.—An ACO shall meet the  
25 following requirements:

1 (A) The ACO shall have a formal legal  
2 structure that would allow the organization to  
3 receive and distribute bonuses to participating  
4 providers.

5 (B) The ACO shall include the primary  
6 care providers of at least 5,000 Medicare fee-  
7 for-service beneficiaries.

8 (C) The ACO shall be willing to become  
9 accountable for the overall care of the Medicare  
10 fee-for-service beneficiaries.

11 (D) The ACO shall provide the Secretary  
12 with a list of primary care and specialist physi-  
13 cians participating in the ACO to support the  
14 beneficiary assignment, implementation of per-  
15 formance measures, and the determination of  
16 bonus payments under the demonstration pro-  
17 gram.

18 (E) The ACO shall have in place contracts  
19 with a core group of key specialist physicians,  
20 a leadership and management structure, and  
21 processes to promote evidence-based medicine  
22 and to coordinate care.

23 (c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE  
24 BENEFICIARIES.—

1 (1) IN GENERAL.—Under the demonstration  
 2 program under this section, each Medicare fee-for-  
 3 service Medicare beneficiary shall be automatically  
 4 assigned to a primary care provider. Such assign-  
 5 ment shall be based on the physician from whom the  
 6 beneficiary received the most primary care in the  
 7 preceding year.

8 (2) BENEFICIARIES MAY CONTINUE TO SEE  
 9 PROVIDERS OUTSIDE OF THE ACO.—Under the dem-  
 10 onstration program under this section, a Medicare  
 11 fee-for-service Medicare beneficiary may continue to  
 12 see providers in and outside of the ACO to which  
 13 they have been assigned.

14 (d) BONUS PAYMENTS.—

15 (1) IN GENERAL.—Under the demonstration  
 16 program, Medicare payments shall continue to be  
 17 made to providers under the original Medicare fee-  
 18 for-service program in the same manner as they  
 19 would otherwise be made except that a participating  
 20 ACO is eligible for bonuses if—

21 (A) it meets certain quality performance  
 22 measures; and

23 (B) spending for their Medicare fee-for-  
 24 service beneficiaries meets the requirement  
 25 under paragraph (3).

1 (2) QUALITY.—Under the demonstration pro-  
 2 gram under this section, providers meet the require-  
 3 ment under paragraph (1)(A) if they generally follow  
 4 consensus-based guidelines established by non-gov-  
 5 ernment professional medical societies. Patient satis-  
 6 faction and risk-adjusted outcomes shall be deter-  
 7 mined through an independent entity with medical  
 8 expertise.

9 (3) REQUIREMENT RELATING TO SPENDING.—

10 (A) IN GENERAL.—An ACO shall only be  
 11 eligible to receive a bonus payment if the aver-  
 12 age Medicare expenditures under the ACO for  
 13 Medicare fee-for-service beneficiaries over a  
 14 two-year period is at least 2 percent below the  
 15 average benchmark for the corresponding two-  
 16 year period. The benchmark for each ACO shall  
 17 be set using the most recent three years of total  
 18 per-beneficiary spending for Medicare fee-for-  
 19 service beneficiaries assigned to the ACO. Such  
 20 benchmark shall be updated by the projected  
 21 rate of growth in national per capita spending  
 22 for the original medicare fee-for-service pro-  
 23 gram, as projected (using the most recent three  
 24 years of data) by the Chief Actuary of the Cen-  
 25 ters for Medicare & Medicaid Services.

1 (4) AMOUNT OF BONUS PAYMENTS.—The  
 2 amount of the bonus payment to a participating  
 3 ACO shall be one-half of the percentage point dif-  
 4 ference between the two-year average of their pa-  
 5 tients' Medicare expenditures and 98 percent of the  
 6 two-year average benchmark. The bonus amount, in  
 7 dollars, shall be equal to the bonus share multiplied  
 8 by the benchmark for the most recent year.

9 (5) LIMITATION.—Bonus payments may only be  
 10 made to an ACO if the primary care provider to  
 11 which the Medicare fee-for-service beneficiary has  
 12 been assigned under subsection (e) elects to partici-  
 13 pate in such ACO.

14 (e) WAIVER AUTHORITY.—The Secretary may waive  
 15 such requirements of titles XI and XVIII of the Social  
 16 Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as  
 17 may be appropriate for the purpose of carrying out the  
 18 demonstration program under this section.

19 (f) REPORT.—Upon completion of the demonstration  
 20 program under this section, the Secretary shall submit to  
 21 Congress a report on the program together with such rec-  
 22 ommendations as the Secretary determines appropriate.

## 1 Subtitle D—Repeal of Unused 2 Stimulus Funds

### 3 SEC. 631. RESCISSION AND REPEAL IN ARRA.

4 (a) RESCISSION.—Of the discretionary appropria-  
 5 tions made available in division A of the American Recov-  
 6 ery and Reinvestment Act of 2009 (Public Law 111–5),  
 7 all unobligated balances are rescinded.

8 (b) REPEAL.—ubtitles B and C of title II and titles  
 9 III through VII of division B of the American Recovery  
 10 and Reinvestment Act of 2009 (Public Law 111–5) are  
 11 repealed.

