199

111TH CONGRESS
1ST SESSION

H. R. _____

To [be provided].

IN THE HOUSE OF REPRESENTATIVES

Mr. HOEKSTRA introduced the following bill; which was referred to the Committee on _____

A BILL

To [be provided].

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "[to be provided] Act of 2009"

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

TITLE I—SMALL BUSINESS FAIRNESS

SEC. 101. SHORT TITLE.

This title may be cited as the "Small Business Health Fairness Act of 2009".

SEC. 102. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

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

"(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis

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

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

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

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

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

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

"(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

"(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

"(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

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

"(1) a plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2009,

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

"(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; trans-

portation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

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

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

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

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

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

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

"(A) BOARD MEMBERSHIP.—

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

"(ii) LIMITATION.—

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

"(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

"(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2009.

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

"(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

"(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

"(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

"(1) each participating employer must be—

"(A) a member of the sponsor,

"(B) the sponsor, or

"(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

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

"(A) active or retired owners (including self-employed individuals), officers, directors, or

employees of, or partners in, participating employers; or

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

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2009, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

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

"(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage

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

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

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

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

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

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

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

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

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

"(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

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

tion to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

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

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

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

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

"(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

"(4) MARKETING REQUIREMENTS.—

"(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

"(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

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

"(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under section 731(a)(1) with respect to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

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

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

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

"(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

"(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

"(i) a reserve sufficient for unearned contributions;

"(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

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

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

"(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

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

"(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority

may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

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

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

"(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

"(1) $500,000, or

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

"(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves, excess/stop loss insurance, and indemnification insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation with respect to any such plan or any class of such plans.

"(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

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

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

"(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—In the case of an association health plan described in subsection

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

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

"(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on ac-

count of the failure of a plan to pay any payment when due.

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

"(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

"(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

"(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

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

"(B) which is guaranteed renewable; and

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

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

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

"(B) which is guaranteed renewable; and

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

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

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

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

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

"(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

"(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

"(A) a representative of the National Association of Insurance Commissioners;

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

"(C) a representative of the State governments, or their interests;

"(D) a representative of existing self-insured arrangements, or their interests;

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

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

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

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

"(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

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

"(A) the sponsor; and

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

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

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

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

"(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

"(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the

120-day period ending with the date of the application, including the following:

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

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

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

tuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

"(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

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

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

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

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

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

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

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

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

"(2) represent such actuary's best estimate of anticipated experience under the plan.

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

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than

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

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

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

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

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent

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

"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

"(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sen-

tence of this subsection are remedied or the plan is terminated.

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

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

"(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

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

"(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

"(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

"(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

"(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

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

"(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

"(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

"(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

"(1) the sponsor and plan administrator;

"(2) each participant;

"(3) each participating employer; and

"(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

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

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

"(f) JURISDICTION OF COURT.—

"(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with

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

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

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

"SEC. 811. STATE ASSESSMENT AUTHORITY.

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

"(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

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

"(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums

or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

"(3) such tax is otherwise nondiscriminatory; and

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

"SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

"(a) DEFINITIONS.—For purposes of this part—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

"(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

"(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

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

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

"(7) INDIVIDUAL MARKET.—

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

"(B) TREATMENT OF VERY SMALL GROUPS.—

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

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

"(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee,

partner, or self-employed individual in relation to the plan.

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

"(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries.

"(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

"(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

"(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of

2009, a person eligible to be a member of the sponsor or one of its member associations.

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

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

"(b) RULES OF CONSTRUCTION.—

"(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

"(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6))

includes any partner in relation to the partnership; and

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

"(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.".

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

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

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

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

"(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with

an association health plan which is certified under part 8.

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

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

"(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as defined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, in-

sofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

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

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

"(B) relating to prompt payment of claims.

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

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

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

(A) in clause (i)(II), by striking "and" at the end;

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

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

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

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

(A) by striking "Nothing" and inserting "(1) Except as provided in paragraph (2), nothing"; and

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

"(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2009 shall be construed to alter, amend, modify, invalidate, impair, or supersede any

provision of this title, except by specific cross-reference to the affected section.".

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

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: "An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.".

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

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of

the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

SEC. 103. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after "control group," the following: "except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single em-

ployer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,";

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

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

"(II) in any other case, the determination";

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

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

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

SEC. 104. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

"(3) being a plan or arrangement described in section 3(40)(A)(i),

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

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

"(n) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

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

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

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

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

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

"(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

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

"(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.".

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

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

named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 105. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

''(d) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

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

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association

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

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

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

SEC. 106. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 1 year after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of

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

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

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

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

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

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

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

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

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

(2) DEFINITIONS.—For purposes of this subsection, the terms "group health plan", "medical care", and "participating employer" shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "association health plan" shall be deemed a

reference to an arrangement referred to in this subsection.

TITLE II—HEALTH SAVINGS AND AFFORDABILITY

SEC. 201. SHORT TITLE OF TITLE.

(a) SHORT TITLE.—This title may be cited as the "Health Savings and Affordability Act of 2009".

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 202. DEDUCTION FOR QUALIFIED HEALTH INSURANCE COSTS OF INDIVIDUALS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (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. COSTS OF QUALIFIED HEALTH INSURANCE.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the amount paid during the taxable year for coverage for the taxpayer, his spouse, and dependents under qualified health insurance.

"(b) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' means insurance which constitutes medical care; except that such term shall not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

"(c) SPECIAL RULES.—

"(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance 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). Any amount taken into account in determining the credit allowed under section 35 shall not be taken into account for purposes of this section.

"(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.".

(b) DEDUCTION ALLOWED IN COMPUTING ADJUSTED GROSS INCOME.—Subsection (a) of section 62 is

amended by inserting before the last sentence the following new paragraph:

"(22) COSTS OF QUALIFIED HEALTH INSURANCE.—The deduction allowed by section 224.".

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

"Sec. 224. Costs of qualified health insurance.".

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

SEC. 203. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HSA ACCOUNT.

(a) IN GENERAL.—Paragraph (3) of section 223(b) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE WHERE BOTH SPOUSES ARE ELIGIBLE INDIVIDUALS WITH 1 ACCOUNT.—If—

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

"(ii) the spouse is not an account beneficiary of a health savings account as of the close of such year,

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 204. INCREASE IN HSA CONTRIBUTION LIMITATION.

(a) IN GENERAL.—Subsection (b) of section 223 (relating to monthly limitation) is amended—

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

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

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 223(g) is amended by striking "subsections (b)(2) and" and inserting "subsection".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions for taxable years beginning after the date of the enactment of this Act.

SEC. 205. TREATMENT OF FAMILY COVERAGE PLANS HAVING BOTH INDIVIDUAL AND FAMILY DEDUCTIBLES.

(a) IN GENERAL.—Paragraph (2) of section 223(c) (defining high deductible plan) is amended by adding at the end the following new subparagraph:

"(E) FAMILY COVERAGE PLANS HAVING BOTH INDIVIDUAL AND FAMILY DEDUCTIBLES.—In the case of a family coverage plan having a deductible (and the same deductible) for each covered individual and a deductible for the family as a whole, the requirement of subparagraph (A)(i) shall be treated as met if (without regard to this subparagraph)—

"(i) the individual deductible meets the requirement of subparagraph (A)(i)(I), or

"(ii) the family deductible meets the requirement of subparagraph (A)(i)(II).".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 206. FSA AND HRA TERMINATION TO FUND HSAS.

(a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA PARTICIPANTS.—Section 223(c)(1)(B) is amended—

(1) by striking "and" at the end of clause (ii),

(2) by striking the period at the end of clause (iii) and inserting ", and", and

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

"(iv) coverage under a health flexible spending arrangement or a health reimbursement arrangement in the plan year a qualified HSA distribution as described in section 106(e) is made on behalf of the individual if after the qualified HSA distribution is made and for the remaining duration of the plan year, the coverage provided under the health flexible spending arrangement or health reimbursement arrangement is converted to—

"(I) coverage that does not pay or reimburse any medical expense incurred before the minimum annual deductible under section 223(c)(2)(A)(i) (prorated for the period occurring after the qualified HSA distribution is made) is satisfied,

"(II) coverage that, after the qualified HSA distribution is made,

does not pay or reimburse any medical expense incurred after the qualified HSA distribution is made other than preventive care as defined in section 223(c)(2)(C),

"(III) coverage that, after the qualified HSA distribution is made, pays or reimburses benefits for coverage described in section 223(c)(1)(B)(ii) (but not through insurance or for long-term care services),

"(IV) coverage that, after the qualified HSA distribution is made, pays or reimburses benefits for permitted insurance as defined in section 223(c)(1)(B)(i) or coverage described in section 223(c)(1)(B)(ii) (but not for long-term care services),

"(V) coverage that, after the qualified HSA distribution is made, pays or reimburses only those medical expenses incurred after an individual's retirement (and no expenses incurred before retirement), or

"(VI) coverage that, after the qualified HSA distribution is made, is suspended, pursuant to an election made on or before the date the individual elects a qualified HSA distribution or, if later, on the date of the individual enrolls in a high deductible health plan (as defined in section 223(c)(2)), that does not pay or reimburse, at any time, any medical expense incurred during the suspension period except as defined in subclauses (I) through (V) above.".

(b) QUALIFIED HSA DISTRIBUTION SHALL NOT AFFECT FLEXIBLE SPENDING ARRANGEMENT.—Section 106(e)(1) is amended to read as follows:

"(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement under this section, section 105, or section 125, or as a health reimbursement arrangement under this section or section 105, merely because such plan provides for a qualified HSA distribution.".

(c) FSA BALANCES AT YEAR END SHALL NOT FORFEIT.—Section 125(d)(2) is amended by adding at the end the following new subparagraph:

"(E) EXCEPTION FOR QUALIFIED HSA DISTRIBUTIONS.—Subparagraph (A) shall not apply to the extent that there is an amount remaining in a health flexible spending account at the end of a plan year that an individual elects to contribute to a health savings account pursuant to a qualified HSA distribution (as defined in section 106(e)(2)).".

(d) SIMPLIFICATION OF LIMITATIONS ON FSA AND HRA ROLLOVERS.—Section 106(e)(2) (relating to qualified HSA distribution) is amended to read as follows:

"(2) QUALIFIED HSA DISTRIBUTION.—

"(A) IN GENERAL.—The term 'qualified HSA distribution' means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution does not exceed the lesser of—

"(i) the balance in such arrangement as of the date of such distribution, or

"(ii) the amount determined under subparagraph (B).

Such term shall not include more than 1 distribution with respect to any arrangement.

"(B) DOLLAR LIMITATIONS.—

"(i) DISTRIBUTIONS FROM A HEALTH FLEXIBLE SPENDING ARRANGEMENT.—A qualified HSA distribution from a health flexible spending arrangement shall not exceed the applicable amount.

"(ii) DISTRIBUTIONS FROM A HEALTH REIMBURSEMENT ARRANGEMENT.—A qualified HSA distribution from a health reimbursement arrangement shall not exceed—

"(I) the applicable amount divided by 12, multiplied by

"(II) the number of months during which the individual is a participant in the health reimbursement arrangement.

"(iii) APPLICABLE AMOUNT.—For purposes of this subparagraph, the applicable amount is—

"(I) $2,250 in the case of an eligible individual who has self-only coverage under a high deductible health plan at the time of such distribution, and

"(II) $4,500 in the case of an eligible individual who has family coverage under a high deductible health plan at the time of such distribution.".

(e) ELIMINATION OF ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—Section 106(e) is amended—

(1) by striking paragraph (3) and redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively, and

(2) by striking subparagraph (A) of paragraph (3), as so redesignated, and redesignating subparagraphs (B) and (C) of such paragraph as subparagraphs (A) and (B) thereof, respectively.

(f) LIMITED PURPOSE FSAS AND HRAS.—Section 106(e), as amended by this section, is amended by adding at the end the following new paragraph:

"(5) LIMITED PURPOSE FSAS AND HRAS.—A plan shall not fail to be a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because the plan converts coverage for individuals who enroll in a high deductible health plan described in section 223(e)(2) to coverage described in section

223(c)(1)(B)(iv). Coverage for such individuals may be converted as of the date of enrollment in the high deductible health plan, without regard to the period of coverage under the health flexible spending arrangement or health reimbursement arrangement, and without requiring any change in coverage to individuals who do not enroll in a high deductible health plan.".

(g) DISTRIBUTION AMOUNTS ADJUSTED FOR COST-OF-LIVING.—Section 106(e), as amended by this section, is amended by adding at the end the following new paragraph:

"(6) COST-OF-LIVING ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any taxable year beginning after December 31, 2010, each of the dollar amounts in paragraph (2)(B)(iii) shall be increased by an amount equal to such dollar amount, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

"(B) ROUNDING.—If any increase under subparagraph (A) is not a multiple of $50, such

increase shall be rounded to the nearest multiple of $50.".

(h) DISCLAIMER OF DISQUALIFYING COVERAGE.—Section 223(c)(1)(B), as amended by this section, is amended—

(1) by striking "and" at the end of clause (iii),

(2) by striking the period at the end of clause (iv) and inserting ", and", and

(3) by inserting after clause (iv) the following new clause:

"(v) any coverage (including prospective coverage) under a health plan that is not a high deductible health plan which is disclaimed in writing, at the time of the creation or organization of the health savings account, including by execution of a trust described in subsection (d)(1) through a governing instrument that includes such a disclaimer, or by acceptance of an amendment to such a trust that includes such a disclaimer.".

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

SEC. 207. PURCHASE OF HEALTH INSURANCE FROM HSA ACCOUNT.

(a) IN GENERAL.—Paragraph (2) of section 223(d) (defining qualified medical expenses) is amended to read as follows:

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d)) for any individual covered by a high deductible health plan of the account beneficiary, but only to the extent such amounts are not compensated for by insurance or otherwise.

"(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Except as provided in subparagraph (C), subparagraph (A) shall not apply to any payment for insurance.

"(C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—

"(i) a health plan during any period of continuation coverage required under any Federal law,

"(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

"(iii) a health plan during any period in which the individual is receiving unemployment compensation under any Federal or State law,

"(iv) a high deductible health plan, or

"(v) any health insurance under title XVIII of the Social Security Act, other than a Medicare supplemental policy (as defined in section 1882 of such Act).".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years beginning after such date.

SEC. 208. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL FITNESS PROGRAMS TREATED AS MEDICAL CARE.

(a) IN GENERAL.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(12) EXERCISE EQUIPMENT AND PHYSICAL FITNESS PROGRAMS.—

"(A) IN GENERAL.—The term 'medical care' shall include amounts paid—

"(i) to purchase or use equipment used in a program (including a self-directed program) of physical exercise,

"(ii) to participate, or receive instruction, in a program of physical exercise, and

"(iii) for membership dues in a fitness club the primary purpose of which is to provide access to equipment and facilities for physical exercise.

"(B) LIMITATION.—Amounts treated as medical care under subparagraph (A) shall not exceed $1,200 with respect to any individual for any taxable year.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

TITLE III—HEALTH CARE CHOICE

SEC. 301. SHORT TITLE.

This title may be cited as "Health Care Choice Act of 2009".

SEC. 302. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This title is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. 303. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. 304. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

"In this part:

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

"(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insur-

ance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

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

"(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

"(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

"(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that,

based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

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

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

"(7) COVERED LAWS.—

"(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

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

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

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

"(iv) the provision to an individual in relation to individual health insurance cov-

erage of management, operations, and investment activities of a health insurance issuer; and

"(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

"(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

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

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

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

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

"(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

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

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

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

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

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

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

"(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

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

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

"(A) Presenting, causing to be presented or preparing with knowledge or belief that it

will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

"(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

"(ii) The rating of an insurance policy or reinsurance contract.

"(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

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

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

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

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

"(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of in-

surance or reinsurance in all or part of a State by an insurer or reinsurer.

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

"(x) The reinstatement of an insurance policy.

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

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

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

"SEC. 2796. APPLICATION OF LAW.

"(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State

and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

"(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

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

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

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

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

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

"(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

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

"(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

"(ii) in a voluntary dissolution proceeding;

"(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

"(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

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

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

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

"(2) require any individual health insurance coverage issued by the issuer to be countersigned by

an insurance agent or broker residing in that Secondary State; or

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

"(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned: 'Notice: This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of

_____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'

"(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

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

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

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

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

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

"(B) from raising premium rates for all policy holders within a class based on claims experience;

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

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

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

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

"(D) from reinstating lapsed coverage; or

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

"(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale

individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

"(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

"(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

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

"(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which

shall include the name of its primary State and its principal place of business);

"(B) written notice of any change in its designation of its primary State; and

"(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

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

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

"(B) a qualified loss reserve specialist.

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

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

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

"(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

"(j) STATE POWERS TO ENFORCE STATE LAWS.—

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

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

"(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

"(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

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

"SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

"A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary

State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

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

"(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review

is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

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

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

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

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

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

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

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

"(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

"(3) INDEPENDENCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

nosis, or provides the type of treatment under review.

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

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

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

"(A) not exceed a reasonable level; and

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

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

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

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

"(C) The health care professional that provides the items or services involved in the denial.

"(D) The institution at which the items or services (or treatment) involved in the denial are provided.

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

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

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

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

"(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care

services and who is operating within the scope of such licensure, accreditation, or certification.

"SEC. 2799. ENFORCEMENT.

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

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

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

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

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance

coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

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

(C) the availability and cost of health insurance policies generally;

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

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

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

TITLE IV—MEDICAL LIABILITY REFORM

SEC. 401. SHORT TITLE.

This title may be cited as the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2009".

SEC. 402. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to

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

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

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

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

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

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

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of "defensive medicine" and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

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

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

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

SEC. 403. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

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

SEC. 404. COMPENSATING PATIENT INJURY.

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

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

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

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

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

this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 405. MAXIMIZING PATIENT RECOVERY.

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

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

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

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

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

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

SEC. 406. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled

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

SEC. 407. PUNITIVE DAMAGES.

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

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

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

(D) the number of products sold or medical procedures rendered for compensation, as

the case may be, by such party, of the kind causing the harm complained of by the claimant;

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

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

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

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

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

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

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

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

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

ices (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

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

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

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.

SEC. 408. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

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

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

SEC. 409. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term "claimant" means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

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

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

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

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

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

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term "compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term "compensatory damages" includes economic damages and noneconomic damages, as such terms are defined in this section.

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

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

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

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plain-

tiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-

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

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

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

(12) HEALTH CARE GOODS OR SERVICES.—The term "health care goods or services" means any goods or services provided by a health care organization, provider, or by any individual working under

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

(13) MALICIOUS INTENT TO INJURE.—The term "malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

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

(15) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of do-

mestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

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

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

(18) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and

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

SEC. 410. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

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

SEC. 411. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

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

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

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

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this title or create a cause of action.

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

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

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

SEC. 412. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be

governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SEC. 413. SENSE OF CONGRESS.

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

TITLE V—ASSURING COVERAGE FOR AMERICANS WITH PRE-EXISTING CONDITIONS

SEC. 501. SHORT TITLE.

This title may be cited as the "Assuring Coverage for Americans with Pre-existing Conditions Act of 2009".

SEC. 502. FEDERAL MATCHING FUNDING FOR STATE INSURANCE EXPENDITURES.

(a) IN GENERAL.—Subject to the succeeding provisions of this section, each State shall receive from the Secretary of Health and Human Services an amount equal to 50 percent of the funds expended by the State in providing for the use, in connection with providing health benefits coverage, of a high-risk pool, a reinsurance pool, or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of private health insurance.

(b) FUNDING LIMITATION.—A State shall not receive under this section for a fiscal year more than a total of

50 cents multiplied by the average number of residents (as estimated by the Secretary) in the State in the fiscal year.

(c) ADMINISTRATION.—The Secretary of Health and Human Services shall provide for the administration of this section and may establish such terms and conditions, including the requirement of an application, as may be appropriate to carry out this section.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring a State to operate a reinsurance pool (or other risk-adjustment mechanism) under this section or as preventing a State from operating such a pool or mechanism through one or more private entities.

(e) HIGH-RISK POOL.—For purposes of this section, the term "high-risk pool" means any qualified high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

(f) REINSURANCE POOL OR OTHER RISK-ADJUSTMENT MECHANISM DEFINED.—For purposes of this section, the term "reinsurance pool or other risk-adjustment mechanism" means any State-based risk spreading mechanism to subsidize the purchase of private health insurance for the high-risk population.

(g) HIGH-RISK POPULATION.—For purposes of this section, the term "high-risk population" means—

(1) individuals who, by reason of the existence or history of a medical condition, are able to acquire health coverage only at rates which are at least 150 percent of the standard risk rates for such coverage, and

(2) individuals who are provided health coverage by a high-risk pool.

(h) STATE DEFINED.—For purposes of this section, the term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

TITLE VI—COMMUNITIES BUILDING ACCESS

SEC. 601. SHORT TITLE.

This title may be cited as the "Communities Building Access Act".

SEC. 602. FINDINGS.

The Congress finds as follows:

(1) Two models of community programs for the uninsured have emerged as effective in generating community support and funding in urban and rural areas; in providing effective care and coverage for the uninsured; in avoiding displacement of private coverage; and in avoiding duplication of other Federal programs for the uninsured.

(2) These community models have demonstrated community-wide economic benefit. Employers in the community experience less health care cost-shifting, in addition to increased productivity and employee retention. With greater emphasis on preventive and chronic care, a community's uninsured population becomes less of a financial burden on State and local budgets.

(3) These community models have demonstrated potential national solutions for certain uninsured populations, including the working uninsured. Such lessons learned from these models include, for example, the level of subsidy necessary to get small employers to purchase coverage for their employees, how to effectively market access programs to the uninsured, and how to effectively manage chronic care among lower-income populations.

(4) These community models have succeeded in raising much of the funding necessary to function, but have lacked financial stability and would enjoy greater success with a stable partial funding stream from the Federal Government.

(5) These community models, if involved in a Federal partnership, have the ability and willingness to be accountable for a return on investment for

Federal funding, and to disseminate expertise to like-minded communities.

SEC. 603. GRANTS FOR MULTI-SHARE HEALTH CARE COVERAGE PROJECTS FOR UNINSURED WORKING INDIVIDUALS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"SEC. 330M. MULTI-SHARE HEALTH CARE COVERAGE PROJECTS FOR UNINSURED WORKING INDIVIDUALS.

"(a) IN GENERAL.—The Secretary shall make grants to public or nonprofit private entities to carry out demonstration projects for the purpose of—

"(1) making available, on a cost-sharing basis as described in subsection (c)(2)(C), health care coverage to qualifying employees through employers that have not contributed to health care benefits for employees during the 12-month period prior to participating in such a project; and

"(2) making available, on such basis, health care coverage to qualifying self-employed individuals who have been without such coverage during the 12-month period prior to participating in such a project.

"(b) QUALIFYING EMPLOYEES AND SELF-EMPLOYED INDIVIDUALS.—For purposes of this section, the term 'qualifying', with respect to an employee or self-employed individual, means that the employee or self-employed individual is not eligible for health services under the program under title XVIII, XIX, or XXI of the Social Security Act (relating to the Medicare program, the Medicaid program, and the State children's health insurance program, respectively).

"(c) REQUIREMENTS FOR GRANT.—

"(1) IN GENERAL.—A grant may be made under subsection (a) for a project only if the applicant involved—

"(A) has defined a service area for the project;

"(B) has formed a consortium of entities in such service area, which consortium is composed of employers whose employees may or may not be served by the project, health care providers who will provide services through the project, and other appropriate entities;

"(C) has ensured that the consortium has established a set of unified goals for the project;

"(D) has conducted a basic level of demographic research to obtain data on the unin-

sured businesses, working uninsured, and provider community within the service area in order to determine the potential value and effectiveness of operating such a project, which data includes—

"(i) the rate of uncompensated care;

"(ii) the number of women lacking prenatal services;

"(iii) immunization rates; and

"(iv) the number of employers that do not provide health insurance to their employees; and

"(E) has conducted a basic evaluation of State health insurance and local laws that might impact the implementation of the project.

"(2) AGREEMENTS.—A grant may be made under subsection (a) for a project only if the applicant involved agrees as follows:

"(A) Eligibility criteria will be established for employers to participate in the project, including the requirement that the employers be located within the service area defined under paragraph (1)(A) for the project, which may include—

"(i) a maximum average income earned by the employees of the business;

"(ii) criteria, in addition to the 12-month periods under subsection (a), to avoid creating any incentive for an employer or self-employed individual to discontinue health plans or health insurance policies; and

"(iii) such other criteria as the consortium under paragraph (1)(B) considers to be appropriate.

"(B) A network of health care providers will be formed to provide services to qualifying employees and self-employed individuals who participate in the project, which services will be provided according to a schedule of fees and co-payments negotiated by the project.

"(C) Of the cost of providing health care coverage through the project—

"(i) not more than 30 percent will be paid by the project with funds from the grant; and

"(ii) not less than 70 percent will be paid by the employer, the employee, and any additional sources of funds (such as

the community in which the project is located) that may be available pursuant to arrangements with the project.

"(D) A minimum benefit package will be selected that includes—

"(i) physicians services;

"(ii) prescription drug benefits;

"(iii) in-patient hospital services;

"(iv) out-patient services;

"(v) emergency room visits;

"(vi) emergency ambulance services; and

"(vii) diagnostic laboratory tests and x-rays.

With respect to compliance with the agreement under this subparagraph, the project is not required to provide coverage for any service performed outside the service area of the project, except to the extent that a service specified in any of clauses (i) through (vii) is not reasonably available within the service area.

"(E) The minimum benefit package will not exclude coverage of a medical condition on the basis that it is a pre-existing condition.

"(F) An entity will be selected by the consortium under paragraph (1)(B) to carry out administrative and accounting functions with respect to the health care coverage to be offered by the project, including monthly billings, verification and enrollment of eligible employers and employees, maintenance of membership rosters, operation of the utilization management program under subparagraph (G), and development of a marketing plan.

"(G) A utilization management program will be selected that ensures delivery of care in the appropriate setting, using appropriate resources and clinical practice guidelines.

"(H) A plan will be implemented for measuring quality and efficiency of care provided through the project within 2 years after the project begins operation.

"(I) A plan will be implemented for managing care for enrollees with chronic illness, as well as additional cost-control initiatives that will be employed by the project within 2 years after the project begins operation.

"(J) A plan will be implemented for protecting the project from high risks, which may

include affiliation with State high-risk pool or local safety net program, and purchase of reinsurance.

"(K) A plan will be implemented for evaluating the project on an interim basis, not less frequently than annually.

"(d) APPLICATION FOR GRANT.—A grant may be made under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of making grants under subsection (a), there is authorized to be appropriated $36,000,000 in the aggregate for the fiscal years 2010 through 2016, of which there are authorized to be appropriated amounts as follows:

"(1) For fiscal year 2010, $2,000,000.

"(2) For each of the fiscal years 2011 and 2012, $5,000,000.

"(3) For each of the fiscal years 2013 through 2016, $6,000,000.

"SEC. 330N. GRANTS FOR VOLUNTEER SPECIALTY PROVIDER NETWORKS.

"(a) IN GENERAL.—The Secretary shall make grants to public or nonprofit private entities to carry out demonstration projects for the purpose of forming and maintaining networks composed of health care specialists who volunteer health services to eligible individuals.

"(b) ELIGIBLE INDIVIDUALS.—For purposes of this section, the term 'eligible individual' means an individual who has been enrolled by a project under subsection (a) and—

"(1) whose employer does not provide health care coverage;

"(2) is unable to obtain health care coverage through a family member or common law partner;

"(3) is at or below a poverty level specified by the Secretary; and

"(4) is not eligible for health services under the program under title XVIII, XIX, or XXI of the Social Security Act (relating to the Medicare program, the Medicaid program, and the State children's health insurance program, respectively).

"(c) QUALIFIED GRANT EXPENDITURES.—A grant may be made under subsection (a) for a project only if the applicant involved agrees that the grant will be expended to assist specialists that are participants in the

network involved through any or all of the following means:

"(1) Paying nominal administrative fees to the participants for the costs of providing services to eligible individuals.

"(2) Assisting with the cost of training primary care practitioners to manage the chronic conditions that are most often treated by the network specialists.

"(3) Assisting participants with the costs of providing fees to recruit specialists to practice in the service area of the project.

"(4) Assisting with the costs of operating a community clinic staffed by volunteer network specialists.

"(5) Assisting participants with the costs of installing or operating information technology that is of benefit to patients, such as technology to avoid medical errors or to facilitate the authorized electronic transfer of the health records of eligible individuals.

"(6) Paying for necessary prescription drug costs for necessary treatment prescribed by network specialists.

"(7) Such additional means as the Secretary may authorize.

"(d) CERTAIN REQUIREMENTS FOR GRANT.—A grant may be made under subsection (a) for a project only if the applicant involved—

"(1) has defined a service area for the project;

"(2) has formed a consortium of various community members, leaders, and organizations in such area;

"(3) has ensured that the consortium has established a set of unified goals for the project;

"(4) has conducted the basic level of demographic research described in section 330M(c)(1)(D);

"(5) has a plan for managing the care of eligible individuals with chronic illness; and

"(6) has a plan for evaluating the project on an interim basis, not less frequently than once each year.

"(e) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of the project to be carried out under subsection (a) by an applicant, a grant under such subsection may be made only if the applicant agrees to make available (directly or through donations from public or private

entities) non-Federal contributions toward such costs in an amount that is not less than ⅓ of such costs ($1 for each $2 provided in the grant).

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(f) APPLICATION FOR GRANT.—A grant may be made under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of making grants under subsection (a), there is authorized to be appropriated $9,000,000 in the aggregate for the fiscal years 2010 through 2016, of which there are authorized to be appropriated amounts as follows:

"(1) For each of the fiscal years 2010 and 2011, $500,000.

"(2) For each of the fiscal years 2012 and 2013, $1,000,000.

"(3) For each of the fiscal years 2014 through 2016, $2,000,000.

"SEC. 330O. CLEARINGHOUSE FOR INFORMATION ON COMMUNITY-INITIATED PROJECTS TO PROVIDE HEALTH CARE COVERAGE TO UNINSURED INDIVIDUALS.

"(a) IN GENERAL.—The Secretary shall make an award of a grant or contract for the establishment and operation of a clearinghouse to collect and make available, on a national basis, information on projects under sections 330M and 330N and similar projects that are community-initiated (referred to in this section as 'access projects').

"(b) CERTAIN REQUIREMENTS.—The Secretary shall ensure that the information collected and made available under subsection (a) by the Clearinghouse includes the following:

"(1) A database identifying technical-assistance experts who are or have been involved in the planning or operation of access projects.

"(2) Information regarding the success and progress of access projects, including—

"(A) information on best-practices identified for such projects;

"(B) the number of individuals who lacked health care coverage prior to receiving such coverage through the projects;

"(C) the number of individuals served by the projects who have chronic conditions that are managed by the projects;

"(D) the economic impact of the projects for businesses in the communities in which the projects operated; and

"(E) the savings of hospitals and other health care providers in such communities that resulted from the operation of the projects.

"(c) APPLICATION.—An award may be made under subsection (a) only if an application for the award is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(d) SOLICITATION OF REPORTS.—The Secretary may carry out a program to encourage public and private entities that plan or operate access projects to submit to the Clearinghouse reports that provide information on the projects.

"(e) DEFINITION.—For purposes of this section, the term 'Clearinghouse' means the clearinghouse under subsection (a).

"(f) AUTHORIZATION OF APPROPRIATION.—For the purpose of making awards under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2016.".

TITLE VII—REFUNDABLE AND ADVANCEABLE CREDIT FOR MEDICAL COSTS

SEC. 701. REFUNDABLE AND ADVANCEABLE CREDIT FOR MEDICAL COSTS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"SEC. 36B. MEDICAL COSTS.

"(a) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the sum of—

"(1) the amount paid by the taxpayer during the taxable year for qualified health insurance for coverage of the taxpayer, his spouse, and dependents, and

"(2) the amount paid by the taxpayer during the taxable year for medical care for the taxpayer, his spouse, and his dependents.

"(b) LIMITATION.—The amount allowed as a credit under subsection (a) for a taxable year shall not exceed $2,500 ($5,000 in the case of a joint return).

"(c) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means an individual who is—

"(1) a citizen or national of the United States, or

"(2) lawfully present in the United States.

"(d) MEDICAL CARE.—For purposes of this section, the term 'medical care' has the meaning given such term by section 213(d), determined without regard to subparagraphs (C) and (D) of paragraph (1) thereof.

"(e) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care.

"(2) EMPLOYER SUBSIDIZED COVERAGE.—Such term shall not include amounts paid for coverage of any individual for any month for which such individual participates in any subsidized health plan

maintained by any employer of the taxpayer or of the spouse of the taxpayer. For purposes of the preceding sentence, the rule of the last sentence of section 162(l)(2)(B) shall apply and health care flexible spending accounts and health reimbursement arrangements shall not be treated as a subsidized health plan maintained by any employer.

"(3) GOVERNMENTAL COVERAGE.—Such term shall not include medical care provided through a program described in—

"(A) title XVIII or XIX of the Social Security Act,

"(B) chapter 55 of title 10, United States Code,

"(C) chapter 17 of title 38, United States Code,

"(D) chapter 89 of title 5, United States Code, or

"(E) the Indian Health Care Improvement Act, and

"(4) EXCLUSION OF CERTAIN PLANS.—Such term does not include insurance if substantially all of its coverage is coverage described in section 223(c)(1)(B).

"(f) SPECIAL RULES.—

"(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a credit under section 35 or as a deduction under section 162(l) or 213(a).

"(2) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT; RECAPTURE OF EXCESS ADVANCE PAYMENTS.—With respect to any taxable year—

"(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, and

"(B) the tax imposed by section 1 for such taxable year shall be increased by the excess (if any) of—

"(i) the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, over

"(ii) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a).

"(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(4) MARRIED COUPLES MUST FILE JOINT RETURN.—

"(A) IN GENERAL.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

"(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

"(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section to any individual unless such individual's coverage under qualified health insurance, and the amount paid for such

coverage, are verified in such manner as the Secretary may prescribe.

"(6) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2010, each dollar amount contained in subsection (b) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $10.".

(b) ADVANCE PAYMENT.—

(1) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following:

"SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR MEDICAL COSTS.

"The Secretary shall establish a program for—

"(1) making payments to providers of qualified health insurance (as defined in section 36B(e)) on behalf of taxpayers eligible for the credit under section 36B, and

"(2) making payments relating to medical care for which a credit is allowable under such section.".

(2) INFORMATION REPORTING.—

(A) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code (relating to information concerning transactions with other persons) is amended by adding at the end the following new section:

"SEC. 6050X. RETURNS RELATING TO CREDIT FOR MEDICAL COSTS.

"(a) REQUIREMENT OF REPORTING.—Every person who receives payments for any month of any calendar year under section 7529 with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

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

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

"(2) contains—

"(A) the name, address, and TIN of each individual referred to in subsection (a), and

"(B) such other information as the Secretary may prescribe.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

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

"(2) the information required to be shown on the return with respect to such individual.

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

(B) ASSESSABLE PENALTIES.—

(i) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by striking "or" at the end of clause (xxii), by striking "and" at the end of clause (xxiii) and inserting "or",

and by inserting after clause (xxiii) the following new clause:

"(xxiv) section 6050X (relating to returns relating to credit for medical costs), and".

(ii) Paragraph (2) of section 6724(d) of such Code is amended by striking the period at the end of subparagraph (EE) and inserting a comma, by striking the period at the end of subparagraph (FF) and inserting ", or", and by adding after subparagraph (FF) the following new subparagraph:

"(GG) section 6050X (relating to returns relating to credit for medical costs).".

(3) CLERICAL AMENDMENTS.—

(A) The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

"Sec. 7529. Advance payment of credit for medical costs.".

(B) The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

"Sec. 6050X. Returns relating to credit for medical costs.".

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting "36B," after "35A,".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 36 and inserting the following new items:

"Sec. 36B. Medical costs.".

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