I

106TH CONGRESS
1ST SESSION

H. R. 2990

To amend the Internal Revenue Code of 1986 to allow individuals greater access to health insurance through a health care tax deduction, a long-term care deduction, and other health-related tax incentives, to amend the Employee Retirement Income Security Act of 1974 to provide access to and choice in health care through association health plans, to amend the Public Health Service Act to create new pooling opportunities for small employers to obtain greater access to health coverage through HealthMarts, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 30, 1999

Mr. TALENT (for himself, Mr. SHADEGG, Mr. HASTERT, Mr. ARMEY, and Mr. ARCHER) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986 to allow individuals greater access to health insurance through a health care tax deduction, a long-term care deduction, and other health-related tax incentives, to amend the Employee Retirement Income Security Act of 1974 to provide access to and choice in health care through association health plans, to amend the Public Health Service Act to create new pooling opportunities for small employ-

ers to obtain greater access to health coverage through HealthMarts, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 ''Quality Care for the Uninsured Act of 1999''.
6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Purposes.
Sec. 3. Findings relating to health care choice.

TITLE I—TAX-RELATED HEALTH CARE PROVISIONS

Sec. 101. Deduction for health and long-term care insurance costs of individuals not participating in employer-subsidized health plans.
Sec. 102. Deduction for 100 percent of health insurance costs of self-employed individuals.
Sec. 103. Expansion of availability of medical savings accounts.
Sec. 104. Long-term care insurance permitted to be offered under cafeteria plans and flexible spending arrangements.
Sec. 105. Additional personal exemption for taxpayer caring for elderly family member in taxpayer's home.
Sec. 106. Expanded human clinical trials qualifying for orphan drug credit.
Sec. 107. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines; reduction in per dose tax rate.
Sec. 108. Credit for clinical testing research expenses attributable to certain qualified academic institutions including teaching hospitals.

TITLE II—GREATER ACCESS AND CHOICE THROUGH ASSOCIATION HEALTH PLANS

Sec. 201. Rules.

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

"Sec. 807. Requirements for application and related requirements.
"Sec. 808. Notice requirements for voluntary termination.
"Sec. 809. Corrective actions and mandatory termination.
"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
"Sec. 811. State assessment authority.
"Sec. 812. Special rules for church plans.
"Sec. 813. Definitions and rules of construction.
Sec. 202. Clarification of treatment of single employer arrangements.
Sec. 203. Clarification of treatment of certain collectively bargained arrangements.
Sec. 204. Enforcement provisions.
Sec. 205. Cooperation between Federal and State authorities.
Sec. 206. Effective date and transitional and other rules.

TITLE III—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

Sec. 301. Expansion of consumer choice through HealthMarts.

"TITLE XXVIII—HEALTHMARTS

"Sec. 2801. Definition of HealthMart.
"Sec. 2802. Application of certain laws and requirements.
"Sec. 2803. Administration.
"Sec. 2804. Definitions.

TITLE IV—COMMUNITY HEALTH ORGANIZATIONS

Sec. 401. Promotion of provision of insurance by community health organizations.

1 (c) CONSTITUTIONAL AUTHORITY TO ENACT THIS
2 LEGISLATION.—The constitutional authority upon which
3 this Act rests is the power of Congress to regulate com-
4 merce with foreign nations and among the several States,
5 set forth in article I, section 8 of the United States Con-
6 stitution.

7 **SEC. 2. PURPOSES.**

8 The purposes of this Act are—
9 (1) to make it possible for individuals, employ-
10 ees, and the self-employed to purchase and own their

1 own health insurance without suffering any negative
2 tax consequences;
3 (2) to assist individuals in obtaining and in
4 paying for basic health care services;
5 (3) to render patients and deliverers sensitive to
6 the cost of health care, giving them both the incen-
7 tive and the ability to restrain undesired increases in
8 health care costs;
9 (4) to foster the development of numerous, var-
10 ied, and innovative systems of providing health care
11 which will compete against each other in terms of
12 price, service, and quality, and thus allow the Amer-
13 ican people to benefit from competitive forces which
14 will reward efficient and effective deliverers and
15 eliminate those which provide unsatisfactory quality
16 of care or are inefficient; and
17 (5) to encourage the development of systems of
18 delivering health care which are capable of supplying
19 a broad range of health care services in a com-
20 prehensive and systematic manner.

21 **SEC. 3. FINDINGS RELATING TO HEALTH CARE CHOICE.**

22 (a) Congress finds that the majority of Americans are
23 receiving health care of a quality unmatched elsewhere in
24 the world but that 43 million Americans remain without
25 private health insurance. Congress further finds that small

1 business faces significant challenges in the purchase of
2 health insurance, including higher costs and lack of choice
3 of coverage. Congress further finds that such challenges
4 lead to fewer Americans who are able to take advantage
5 of private health insurance, leading to higher cost and
6 lower quality care.

7 (b) Congress finds that reduction of the number of
8 uninsured Americans is an important public policy goal.
9 Congress further finds that the use of alternative pooling
10 mechanisms such as Association Health Plans,
11 HealthMarts and other innovative means could provide
12 significant opportunities for small business and individuals
13 to purchase health insurance. Congress further finds that
14 the use of such mechanisms could provide significant op-
15 portunities to expand private health coverage for individ-
16 uals who are employees of small business, self-employed,
17 or do not work for employers who provide health insur-
18 ance.

19 (c) Congress finds that the current Tax Code pro-
20 vides significant incentives for employers to provide health
21 insurance coverage for their employees by providing a de-
22 duction for the employer for the cost of health insurance
23 coverage and an exclusion from income for the employee
24 for employer-provided health care. Congress further finds
25 that some individuals may prefer to decline coverage under

1 their employer's group health plan and obtain individual
2 health insurance coverage, and some employers may wish
3 to give employees the opportunity to do so. Congress fur-
4 ther finds that the Internal Revenue Service has ruled that
5 this tax treatment for the employer and employee for em-
6 ployer-provided health care applies even if the employer
7 pays for individual health insurance polices for its employ-
8 ees. Therefore, the Tax Code makes it possible for employ-
9 ers to provide employees choice among health insurance
10 coverage while retaining favorable tax treatment. Congress
11 further finds that the present-law exclusion for employer-
12 provided health care, together with the tax provisions in
13 the bill, will provide more equitable tax treatment for
14 health insurance expenses, encourage uninsured individ-
15 uals to purchase insurance, expand health care options,
16 and encourage individuals to better manage their health
17 care needs and expenses.

18 (d) Congress finds that continually increasing and
19 complex government regulation of the health care delivery
20 system has proven ineffective in restraining costs and is
21 itself expensive and counterproductive in fulfilling its pur-
22 poses and detrimental to the care of patients.

TITLE I—TAX-RELATED HEALTH CARE PROVISIONS

SEC. 101. DEDUCTION FOR HEALTH AND LONG-TERM CARE INSURANCE COSTS OF INDIVIDUALS NOT PARTICIPATING IN EMPLOYER-SUBSIDIZED HEALTH PLANS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 222 as section 223 and by inserting after section 221 the following new section:

"SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE COSTS.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.

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

"For taxable years beginning in calendar year—	The applicable percentage is—
2002, 2003, and 2004	25
2005	35
2006	65
2007 and thereafter	100.

"(c) LIMITATION BASED ON OTHER COVERAGE.—

1 "(1) COVERAGE UNDER CERTAIN SUBSIDIZED
2 EMPLOYER PLANS.—
3 "(A) IN GENERAL.—Subsection (a) shall
4 not apply to any taxpayer for any calendar
5 month for which the taxpayer participates in
6 any health plan maintained by any employer of
7 the taxpayer or of the spouse of the taxpayer if
8 50 percent or more of the cost of coverage
9 under such plan (determined under section
10 4980B and without regard to payments made
11 with respect to any coverage described in sub-
12 section (e)) is paid or incurred by the employer.
13 "(B) EMPLOYER CONTRIBUTIONS TO CAF-
14 ETERIA PLANS, FLEXIBLE SPENDING ARRANGE-
15 MENTS, AND MEDICAL SAVINGS ACCOUNTS.—
16 Employer contributions to a cafeteria plan, a
17 flexible spending or similar arrangement, or a
18 medical savings account which are excluded
19 from gross income under section 106 shall be
20 treated for purposes of subparagraph (A) as
21 paid by the employer.
22 "(C) AGGREGATION OF PLANS OF EM-
23 PLOYER.—A health plan which is not otherwise
24 described in subparagraph (A) shall be treated
25 as described in such subparagraph if such plan

1 would be so described if all health plans of per-
2 sons treated as a single employer under sub-
3 section (b), (c), (m), or (o) of section 414 were
4 treated as one health plan.
5 ‘‘(D) SEPARATE APPLICATION TO HEALTH
6 INSURANCE AND LONG-TERM CARE INSUR-
7 ANCE.—Subparagraphs (A) and (C) shall be
8 applied separately with respect to—
9 ‘‘(i) plans which include primarily cov-
10 erage for qualified long-term care services
11 or are qualified long-term care insurance
12 contracts, and
13 ‘‘(ii) plans which do not include such
14 coverage and are not such contracts.
15 ‘‘(2) COVERAGE UNDER CERTAIN FEDERAL
16 PROGRAMS.—
17 ‘‘(A) IN GENERAL.—Subsection (a) shall
18 not apply to any amount paid for any coverage
19 for an individual for any calendar month if, as
20 of the first day of such month, the individual is
21 covered under any medical care program de-
22 scribed in—
23 ‘‘(i) title XVIII, XIX, or XXI of the
24 Social Security Act,

1 "(ii) chapter 55 of title 10, United
2 States Code,
3 "(iii) chapter 17 of title 38, United
4 States Code,
5 "(iv) chapter 89 of title 5, United
6 States Code, or
7 "(v) the Indian Health Care Improve-
8 ment Act.
9 "(B) EXCEPTIONS.—
10 "(i) QUALIFIED LONG-TERM CARE.—
11 Subparagraph (A) shall not apply to
12 amounts paid for coverage under a quali-
13 fied long-term care insurance contract.
14 "(ii) CONTINUATION COVERAGE OF
15 FEHBP.—Subparagraph (A)(iv) shall not
16 apply to coverage which is comparable to
17 continuation coverage under section
18 4980B.
19 "(d) LONG-TERM CARE DEDUCTION LIMITED TO
20 QUALIFIED LONG-TERM CARE INSURANCE CON-
21 TRACTS.—In the case of a qualified long-term care insur-
22 ance contract, only eligible long-term care premiums (as
23 defined in section 213(d)(10)) may be taken into account
24 under subsection (a).

1 ''(e) DEDUCTION NOT AVAILABLE FOR PAYMENT OF
2 ANCILLARY COVERAGE PREMIUMS.—Any amount paid as
3 a premium for insurance which provides for—
4 ''(1) coverage for accidents, disability, dental
5 care, vision care, or a specified illness, or
6 ''(2) making payments of a fixed amount per
7 day (or other period) by reason of being hospitalized,
8 shall not be taken into account under subsection (a).
9 ''(f) SPECIAL RULES.—
10 ''(1) COORDINATION WITH DEDUCTION FOR
11 HEALTH INSURANCE COSTS OF SELF-EMPLOYED IN-
12 DIVIDUALS.—The amount taken into account by the
13 taxpayer in computing the deduction under section
14 162(l) shall not be taken into account under this
15 section.
16 ''(2) COORDINATION WITH MEDICAL EXPENSE
17 DEDUCTION.—The amount taken into account by
18 the taxpayer in computing the deduction under this
19 section shall not be taken into account under section
20 213.
21 ''(g) REGULATIONS.—The Secretary shall prescribe
22 such regulations as may be appropriate to carry out this
23 section, including regulations requiring employers to re-
24 port to their employees and the Secretary such informa-
25 tion as the Secretary determines to be appropriate.''.

1 (b) DEDUCTION ALLOWED WHETHER OR NOT TAX-
2 PAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
3 of section 62 of such Code is amended by inserting after
4 paragraph (17) the following new item:
5 "(18) HEALTH AND LONG-TERM CARE INSUR-
6 ANCE COSTS.—The deduction allowed by section
7 222.".
8 (c) CLERICAL AMENDMENT.—The table of sections
9 for part VII of subchapter B of chapter 1 of such Code
10 is amended by striking the last item and inserting the fol-
11 lowing new items:

"Sec. 222. Health and long-term care insurance costs.
"Sec. 223. Cross reference.".

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to taxable years beginning after
14 December 31, 2001.

15 **SEC. 102. DEDUCTION FOR 100 PERCENT OF HEALTH IN-**
16 **SURANCE COSTS OF SELF-EMPLOYED INDI-**
17 **VIDUALS.**

18 (a) IN GENERAL.—Paragraph (1) of section 162(l)
19 of the Internal Revenue Code of 1986 is amended to read
20 as follows:
21 "(1) ALLOWANCE OF DEDUCTION.—In the case
22 of an individual who is an employee within the
23 meaning of section 401(c)(1), there shall be allowed
24 as a deduction under this section an amount equal

1 to 100 percent of the amount paid during the tax-
2 able year for insurance which constitutes medical
3 care for the taxpayer and the taxpayer's spouse and
4 dependents.''.

5 (b) CLARIFICATION OF LIMITATIONS ON OTHER COV-
6 ERAGE.—The first sentence of section 162(l)(2)(B) of
7 such Code is amended to read as follows: ''Paragraph (1)
8 shall not apply to any taxpayer for any calendar month
9 for which the taxpayer participates in any subsidized
10 health plan maintained by any employer (other than an
11 employer described in section 401(c)(4)) of the taxpayer
12 or the spouse of the taxpayer.''.

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to taxable years beginning after
15 December 31, 2000.

16 **SEC. 103. EXPANSION OF AVAILABILITY OF MEDICAL SAV-**
17 **INGS ACCOUNTS.**

18 (a) REPEAL OF LIMITATIONS ON NUMBER OF MED-
19 ICAL SAVINGS ACCOUNTS.—

20 (1) IN GENERAL.—Subsections (i) and (j) of
21 section 220 of the Internal Revenue Code of 1986
22 are hereby repealed.

23 (2) CONFORMING AMENDMENTS.—

1 (A) Paragraph (1) of section 220(c) of
2 such Code is amended by striking subparagraph
3 (D).

4 (B) Section 138 of such Code is amended
5 by striking subsection (f).

6 (b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR
7 EMPLOYEES OF SMALL EMPLOYERS AND SELF-EM-
8 PLOYED INDIVIDUALS.—

9 (1) IN GENERAL.—Section 220(c)(1)(A) of such
10 Code (relating to eligible individual) is amended to
11 read as follows:

12 ''(A) IN GENERAL.—The term 'eligible in-
13 dividual' means, with respect to any month, any
14 individual if—

15 ''(i) such individual is covered under a
16 high deductible health plan as of the 1st
17 day of such month, and

18 ''(ii) such individual is not, while cov-
19 ered under a high deductible health plan,
20 covered under any health plan—

21 ''(I) which is not a high deduct-
22 ible health plan, and

23 ''(II) which provides coverage for
24 any benefit which is covered under the
25 high deductible health plan.''.

1 (2) CONFORMING AMENDMENTS.—
2 (A) Section 220(c)(1) of such Code is
3 amended by striking subparagraph (C).
4 (B) Section 220(c) of such Code is amend-
5 ed by striking paragraph (4) (defining small
6 employer) and by redesignating paragraph (5)
7 as paragraph (4).
8 (C) Section 220(b) of such Code is amend-
9 ed by striking paragraph (4) (relating to deduc-
10 tion limited by compensation) and by redesig-
11 nating paragraphs (5), (6), and (7) as para-
12 graphs (4), (5), and (6), respectively.
13 (c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED
14 FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—
15 (1) IN GENERAL.—Paragraph (2) of section
16 220(b) of such Code is amended to read as follows:
17 ''(2) MONTHLY LIMITATION.—The monthly lim-
18 itation for any month is the amount equal to 1⁄12 of
19 the annual deductible (as of the first day of such
20 month) of the individual's coverage under the high
21 deductible health plan.''.
22 (2) CONFORMING AMENDMENT.—Clause (ii) of
23 section 220(d)(1)(A) of such Code is amended by
24 striking ''75 percent of''.

1 (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-
2 TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph
3 (5) of section 220(b) of such Code is amended to read
4 as follows:
5 "(5) COORDINATION WITH EXCLUSION FOR EM-
6 PLOYER CONTRIBUTIONS.—The limitation which
7 would (but for this paragraph) apply under this sub-
8 section to the taxpayer for any taxable year shall be
9 reduced (but not below zero) by the amount which
10 would (but for section 106(b)) be includible in the
11 taxpayer's gross income for such taxable year.".
12 (e) REDUCTION OF PERMITTED DEDUCTIBLES
13 UNDER HIGH DEDUCTIBLE HEALTH PLANS.—
14 (1) IN GENERAL.—Subparagraph (A) of section
15 220(c)(2) of such Code (defining high deductible
16 health plan) is amended—
17 (A) by striking "$1,500" in clause (i) and
18 inserting "$1,000", and
19 (B) by striking "$3,000" in clause (ii) and
20 inserting "$2,000".
21 (2) CONFORMING AMENDMENT.—Subsection (g)
22 of section 220 of such Code is amended to read as
23 follows:
24 "(g) COST-OF-LIVING ADJUSTMENT.—

1 "(1) IN GENERAL.—In the case of any taxable
2 year beginning in a calendar year after 1998, each
3 dollar amount in subsection (c)(2) shall be increased
4 by an amount equal to—
5 "(A) such dollar amount, multiplied by
6 "(B) the cost-of-living adjustment deter-
7 mined under section 1(f)(3) for the calendar
8 year in which such taxable year begins by sub-
9 stituting 'calendar year 1997' for 'calendar year
10 1992' in subparagraph (B) thereof.
11 "(2) SPECIAL RULES.—In the case of the
12 $1,000 amount in subsection (c)(2)(A)(i) and the
13 $2,000 amount in subsection (c)(2)(A)(ii), para-
14 graph (1)(B) shall be applied by substituting 'cal-
15 endar year 1999' for 'calendar year 1997'.
16 "(3) ROUNDING.—If any increase under para-
17 graph (1) or (2) is not a multiple of $50, such in-
18 crease shall be rounded to the nearest multiple of
19 $50.
20 (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED
21 UNDER CAFETERIA PLANS.—Subsection (f) of section
22 125 of such Code is amended by striking "106(b),".
23 (g) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to taxable years beginning after
25 December 31, 2000.

1 **SEC. 104. LONG-TERM CARE INSURANCE PERMITTED TO BE**
2 **OFFERED UNDER CAFETERIA PLANS AND**
3 **FLEXIBLE SPENDING ARRANGEMENTS.**

4 (a) CAFETERIA PLANS.—
5 (1) IN GENERAL.—Subsection (f) of section
6 125 of the Internal Revenue Code of 1986 (defining
7 qualified benefits) is amended by inserting before
8 the period at the end ''; except that such term shall
9 include the payment of premiums for any qualified
10 long-term care insurance contract (as defined in sec-
11 tion 7702B) to the extent the amount of such pay-
12 ment does not exceed the eligible long-term care pre-
13 miums (as defined in section 213(d)(10)) for such
14 contract''.
15 (b) FLEXIBLE SPENDING ARRANGEMENTS.—Section
16 106 of such Code (relating to contributions by employer
17 to accident and health plans) is amended by striking sub-
18 section (c).
19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 December 31, 2001.

22 **SEC. 105. ADDITIONAL PERSONAL EXEMPTION FOR TAX-**
23 **PAYER CARING FOR ELDERLY FAMILY MEM-**
24 **BER IN TAXPAYER'S HOME.**

25 (a) IN GENERAL.—Section 151 of the Internal Rev-
26 enue Code of 1986 (relating to allowance of deductions

1 for personal exemptions) is amended by redesignating sub-
2 section (e) as subsection (f) and by inserting after sub-
3 section (d) the following new subsection:

4 "(e) ADDITIONAL EXEMPTION FOR CERTAIN ELDER-
5 LY FAMILY MEMBERS RESIDING WITH TAXPAYER.—

6 "(1) IN GENERAL.—An exemption of the ex-
7 emption amount for each qualified family member of
8 the taxpayer.

9 "(2) QUALIFIED FAMILY MEMBER.—For pur-
10 poses of this subsection, the term 'qualified family
11 member' means, with respect to any taxable year,
12 any individual—

13 "(A) who is an ancestor of the taxpayer or
14 of the taxpayer's spouse or who is the spouse
15 of any such ancestor,

16 "(B) who is a member for the entire tax-
17 able year of a household maintained by the tax-
18 payer, and

19 "(C) who has been certified, before the due
20 date for filing the return of tax for the taxable
21 year (without extensions), by a physician (as
22 defined in section 1861(r)(1) of the Social Se-
23 curity Act) as being an individual with long-
24 term care needs described in paragraph (3) for
25 a period—

1 "(i) which is at least 180 consecutive
2 days, and
3 "(ii) a portion of which occurs within
4 the taxable year.
5 Such term shall not include any individual otherwise
6 meeting the requirements of the preceding sentence
7 unless within the 39½ month period ending on such
8 due date (or such other period as the Secretary pre-
9 scribes) a physician (as so defined) has certified that
10 such individual meets such requirements.
11 "(3) INDIVIDUALS WITH LONG-TERM CARE
12 NEEDS.—An individual is described in this para-
13 graph if the individual—
14 "(A) is unable to perform (without sub-
15 stantial assistance from another individual) at
16 least two activities of daily living (as defined in
17 section 7702B(c)(2)(B)) due to a loss of func-
18 tional capacity, or
19 "(B) requires substantial supervision to
20 protect such individual from threats to health
21 and safety due to severe cognitive impairment
22 and is unable to perform, without reminding or
23 cuing assistance, at least one activity of daily
24 living (as so defined) or to the extent provided
25 in regulations prescribed by the Secretary (in

1 consultation with the Secretary of Health and
2 Human Services), is unable to engage in age
3 appropriate activities.
4 ''(4) SPECIAL RULES.—Rules similar to the
5 rules of paragraphs (1), (2), (3), (4), and (5) of sec-
6 tion 21(e) shall apply for purposes of this sub-
7 section.''.
8 (b) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 2000.

11 **SEC. 106. EXPANDED HUMAN CLINICAL TRIALS QUALI-**
12 **FYING FOR ORPHAN DRUG CREDIT.**

13 (a) IN GENERAL.—Subclause (I) of section
14 45C(b)(2)(A)(ii) of the Internal Revenue Code of 1986 is
15 amended to read as follows:
16 ''(I) after the date that the appli-
17 cation is filed for designation under
18 such section 526, and''.
19 (b) CONFORMING AMENDMENT.—Clause (i) of sec-
20 tion 45C(b)(2)(A) of such Code is amended by inserting
21 ''which is'' before ''being'' and by inserting before the
22 comma at the end ''and which is designated under section
23 526 of such Act''.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to amounts paid or incurred after
3 December 31, 2000.

4 **SEC. 107. INCLUSION OF CERTAIN VACCINES AGAINST**
5 **STREPTOCOCCUS PNEUMONIAE TO LIST OF**
6 **TAXABLE VACCINES; REDUCTION IN PER**
7 **DOSE TAX RATE.**

8 (a) INCLUSION OF VACCINES.—
9 (1) IN GENERAL.—Section 4132(a)(1) of the
10 Internal Revenue Code of 1986 (defining taxable
11 vaccine) is amended by adding at the end the fol-
12 lowing new subparagraph:
13 ''(L) Any conjugate vaccine against strep-
14 tococcus pneumoniae.''.
15 (2) EFFECTIVE DATE.—
16 (A) SALES.—The amendment made by this
17 subsection shall apply to vaccine sales beginning
18 on the day after the date on which the Centers
19 for Disease Control makes a final recommenda-
20 tion for routine administration to children of
21 any conjugate vaccine against streptococcus
22 pneumoniae, but shall not take effect if sub-
23 section (c) does not take effect.
24 (B) DELIVERIES.—For purposes of sub-
25 paragraph (A), in the case of sales on or before

1 the date described in such subparagraph for
2 which delivery is made after such date, the de-
3 livery date shall be considered the sale date.
4 (b) REDUCTION IN PER DOSE TAX RATE.—
5 (1) IN GENERAL.—Section 4131(b)(1) of such
6 Code (relating to amount of tax) is amended by
7 striking ''75 cents'' and inserting ''50 cents''.
8 (2) EFFECTIVE DATE.—
9 (A) SALES.—The amendment made by this
10 subsection shall apply to vaccine sales after De-
11 cember 31, 2004, but shall not take effect if
12 subsection (c) does not take effect.
13 (B) DELIVERIES.—For purposes of sub-
14 paragraph (A), in the case of sales on or before
15 the date described in such subparagraph for
16 which delivery is made after such date, the de-
17 livery date shall be considered the sale date.
18 (3) LIMITATION ON CERTAIN CREDITS OR RE-
19 FUNDS.—For purposes of applying section 4132(b)
20 of the Internal Revenue Code of 1986 with respect
21 to any claim for credit or refund filed after August
22 31, 2004, the amount of tax taken into account shall
23 not exceed the tax computed under the rate in effect
24 on January 1, 2005.

1 (c) VACCINE TAX AND TRUST FUND AMEND-
2 MENTS.—
3 (1) Sections 1503 and 1504 of the Vaccine In-
4 jury Compensation Program Modification Act (and
5 the amendments made by such sections) are hereby
6 repealed.
7 (2) Subparagraph (A) of section 9510(c)(1) of
8 such Code is amended by striking ''August 5, 1997''
9 and inserting ''October 21, 1998''.
10 (3) The amendments made by this subsection
11 shall take effect as if included in the provisions of
12 the Tax and Trade Relief Extension Act of 1998 to
13 which they relate.
14 (d) REPORT.—Not later than December 31, 1999,
15 the Comptroller General of the United States shall prepare
16 and submit a report to the Committee on Ways and Means
17 of the House of Representatives and the Committee on
18 Finance of the Senate on the operation of the Vaccine In-
19 jury Compensation Trust Fund and on the adequacy of
20 such Fund to meet future claims made under the Vaccine
21 Injury Compensation Program.

SEC. 108. CREDIT FOR CLINICAL TESTING RESEARCH EXPENSES ATTRIBUTABLE TO CERTAIN QUALIFIED ACADEMIC INSTITUTIONS INCLUDING TEACHING HOSPITALS.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by inserting after section 41 the following:

"SEC. 41A. CREDIT FOR MEDICAL INNOVATION EXPENSES.

"(a) GENERAL RULE.—For purposes of section 38, the medical innovation credit determined under this section for the taxable year shall be an amount equal to 40 percent of the excess (if any) of—

"(1) the qualified medical innovation expenses for the taxable year, over

"(2) the medical innovation base period amount.

"(b) QUALIFIED MEDICAL INNOVATION EXPENSES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified medical innovation expenses' means the amounts which are paid or incurred by the taxpayer during the taxable year directly or indirectly to any qualified academic institution for clinical testing research activities.

"(2) CLINICAL TESTING RESEARCH ACTIVITIES.—

1 "(A) IN GENERAL.—The term 'clinical
2 testing research activities' means human clinical
3 testing conducted at any qualified academic in-
4 stitution in the development of any product,
5 which occurs before—
6 "(i) the date on which an application
7 with respect to such product is approved
8 under section 505(b), 506, or 507 of the
9 Federal Food, Drug, and Cosmetic Act (as
10 in effect on the date of the enactment of
11 this section),
12 "(ii) the date on which a license for
13 such product is issued under section 351 of
14 the Public Health Service Act (as so in ef-
15 fect), or
16 "(iii) the date classification or ap-
17 proval of such product which is a device in-
18 tended for human use is given under sec-
19 tion 513, 514, or 515 of the Federal Food,
20 Drug, and Cosmetic Act (as so in effect).
21 "(B) PRODUCT.—The term 'product'
22 means any drug, biologic, or medical device.
23 "(3) QUALIFIED ACADEMIC INSTITUTION.—The
24 term 'qualified academic institution' means any of
25 the following institutions:

1 "(A) EDUCATIONAL INSTITUTION.—A
2 qualified organization described in section
3 170(b)(1)(A)(iii) which is owned by, or affili-
4 ated with, an institution of higher education (as
5 defined in section 3304(f)).
6 "(B) TEACHING HOSPITAL.—A teaching
7 hospital which—
8 "(i) is publicly supported or owned by
9 an organization described in section
10 501(c)(3), and
11 "(ii) is affiliated with an organization
12 meeting the requirements of subparagraph
13 (A).
14 "(C) FOUNDATION.—A medical research
15 organization described in section 501(c)(3)
16 (other than a private foundation) which is affili-
17 ated with, or owned by—
18 "(i) an organization meeting the re-
19 quirements of subparagraph (A), or
20 "(ii) a teaching hospital meeting the
21 requirements of subparagraph (B).
22 "(D) CHARITABLE RESEARCH HOS-
23 PITAL.—A hospital that is designated as a can-
24 cer center by the National Cancer Institute.

1 "(4) EXCLUSION FOR AMOUNTS FUNDED BY
2 GRANTS, ETC.—The term 'qualified medical innova-
3 tion expenses' shall not include any amount to the
4 extent such amount is funded by any grant, con-
5 tract, or otherwise by another person (or any gov-
6 ernmental entity).

7 "(c) MEDICAL INNOVATION BASE PERIOD
8 AMOUNT.—For purposes of this section, the term 'medical
9 innovation base period amount' means the average annual
10 qualified medical innovation expenses paid by the taxpayer
11 during the 3-taxable year period ending with the taxable
12 year immediately preceding the first taxable year of the
13 taxpayer beginning after December 31, 2000.

14 "(d) SPECIAL RULES.—

15 "(1) LIMITATION ON FOREIGN TESTING.—No
16 credit shall be allowed under this section with re-
17 spect to any clinical testing research activities con-
18 ducted outside the United States.

19 "(2) CERTAIN RULES MADE APPLICABLE.—
20 Rules similar to the rules of subsections (f) and (g)
21 of section 41 shall apply for purposes of this section.

22 "(3) ELECTION.—This section shall apply to
23 any taxpayer for any taxable year only if such tax-
24 payer elects to have this section apply for such tax-
25 able year.

1 "(4) COORDINATION WITH CREDIT FOR IN-
2 CREASING RESEARCH EXPENDITURES AND WITH
3 CREDIT FOR CLINICAL TESTING EXPENSES FOR CER-
4 TAIN DRUGS FOR RARE DISEASES.—Any qualified
5 medical innovation expense for a taxable year to
6 which an election under this section applies shall not
7 be taken into account for purposes of determining
8 the credit allowable under section 41 or 45C for
9 such taxable year.".
10 (b) CREDIT TO BE PART OF GENERAL BUSINESS
11 CREDIT.—
12 (1) IN GENERAL.—Section 38(b) of such Code
13 (relating to current year business credits) is amend-
14 ed by striking "plus" at the end of paragraph (11),
15 by striking the period at the end of paragraph (12)
16 and inserting ", plus", and by adding at the end the
17 following:
18 "(13) the medical innovation expenses credit
19 determined under section 41A(a).".
20 (2) TRANSITION RULE.—Section 39(d) of such
21 Code is amended by adding at the end the following
22 new paragraph:
23 "(9) NO CARRYBACK OF SECTION 41A CREDIT
24 BEFORE ENACTMENT.—No portion of the unused
25 business credit for any taxable year which is attrib-

1 utable to the medical innovation credit determined
2 under section 41A may be carried back to a taxable
3 year beginning before January 1, 2001.''.
4 (c) DENIAL OF DOUBLE BENEFIT.—Section 280C of
5 such Code is amended by adding at the end the following
6 new subsection:
7 ''(d) CREDIT FOR INCREASING MEDICAL INNOVA-
8 TION EXPENSES.—
9 ''(1) IN GENERAL.—No deduction shall be al-
10 lowed for that portion of the qualified medical inno-
11 vation expenses (as defined in section 41A(b)) other-
12 wise allowable as a deduction for the taxable year
13 which is equal to the amount of the credit deter-
14 mined for such taxable year under section 41A(a).
15 ''(2) CERTAIN RULES TO APPLY.—Rules similar
16 to the rules of paragraphs (2), (3), and (4) of sub-
17 section (c) shall apply for purposes of this sub-
18 section.''.
19 (d) DEDUCTION FOR UNUSED PORTION OF CRED-
20 IT.—Section 196(c) of such Code (defining qualified busi-
21 ness credits) is amended by redesignating paragraphs (5)
22 through (8) as paragraphs (6) through (9), respectively,
23 and by inserting after paragraph (4) the following new
24 paragraph:

1 "(5) the medical innovation expenses credit de-
2 termined under section 41A(a) (other than such
3 credit determined under the rules of section
4 280C(d)(2)),".

5 (e) CLERICAL AMENDMENT.—The table of sections
6 for subpart D of part IV of subchapter A of chapter 1
7 of such Code is amended by adding after the item relating
8 to section 41 the following:

"Sec. 41A. Credit for medical innovation expenses.".

9 (f) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 2000.

12 TITLE II—GREATER ACCESS AND 13 CHOICE THROUGH ASSOCIA- 14 TION HEALTH PLANS

15 **SEC. 201. RULES.**

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

19 "PART 8—RULES GOVERNING ASSOCIATION HEALTH
20 PLANS

21 **"SEC. 801. ASSOCIATION HEALTH PLANS.**

22 "(a) IN GENERAL.—For purposes of this part, the
23 term 'association health plan' means a group health
24 plan—

1 "(1) whose sponsor is (or is deemed under this
2 part to be) described in subsection (b); and
3 "(2) under which at least one option of health
4 insurance coverage offered by a health insurance
5 issuer (which may include, among other options,
6 managed care options, point of service options, and
7 preferred provider options) is provided to partici-
8 pants and beneficiaries, unless, for any plan year,
9 such coverage remains unavailable to the plan de-
10 spite good faith efforts exercised by the plan to se-
11 cure such coverage.
12 "(b) SPONSORSHIP.—The sponsor of a group health
13 plan is described in this subsection if such sponsor—
14 "(1) is organized and maintained in good faith,
15 with a constitution and bylaws specifically stating its
16 purpose and providing for periodic meetings on at
17 least an annual basis, as a bona fide trade associa-
18 tion, a bona fide industry association (including a
19 rural electric cooperative association or a rural tele-
20 phone cooperative association), a bona fide profes-
21 sional association, or a bona fide chamber of com-
22 merce (or similar bona fide business association, in-
23 cluding a corporation or similar organization that
24 operates on a cooperative basis (within the meaning
25 of section 1381 of the Internal Revenue Code of

1 1986)), for substantial purposes other than that of
2 obtaining or providing medical care;
3 ‘‘(2) is established as a permanent entity which
4 receives the active support of its members and col-
5 lects from its members on a periodic basis dues or
6 payments necessary to maintain eligibility for mem-
7 bership in the sponsor; and
8 ‘‘(3) does not condition membership, such dues
9 or payments, or coverage under the plan on the
10 basis of health status-related factors with respect to
11 the employees of its members (or affiliated mem-
12 bers), or the dependents of such employees, and does
13 not condition such dues or payments on the basis of
14 group health plan participation.
15 Any sponsor consisting of an association of entities which
16 meet the requirements of paragraphs (1), (2), and (3)
17 shall be deemed to be a sponsor described in this sub-
18 section.

19 **‘‘SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
20 **PLANS.**

21 ‘‘(a) IN GENERAL.—The applicable authority shall
22 prescribe by regulation, through negotiated rulemaking, a
23 procedure under which, subject to subsection (b), the ap-
24 plicable authority shall certify association health plans

1 which apply for certification as meeting the requirements
2 of this part.

3 "(b) STANDARDS.—Under the procedure prescribed
4 pursuant to subsection (a), in the case of an association
5 health plan that provides at least one benefit option which
6 does not consist of health insurance coverage, the applica-
7 ble authority shall certify such plan as meeting the re-
8 quirements of this part only if the applicable authority is
9 satisfied that—

10 "(1) such certification—

11 "(A) is administratively feasible;

12 "(B) is not adverse to the interests of the
13 individuals covered under the plan; and

14 "(C) is protective of the rights and benefits
15 of the individuals covered under the plan; and

16 "(2) the applicable requirements of this part
17 are met (or, upon the date on which the plan is to
18 commence operations, will be met) with respect to
19 the plan.

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

1 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
2 CATION.—The applicable authority may provide by regula-
3 tion, through negotiated rulemaking, for continued certifi-
4 cation of association health plans under this part.
5 “(e) CLASS CERTIFICATION FOR FULLY INSURED
6 PLANS.—The applicable authority shall establish a class
7 certification procedure for association health plans under
8 which all benefits consist of health insurance coverage.
9 Under such procedure, the applicable authority shall pro-
10 vide for the granting of certification under this part to
11 the plans in each class of such association health plans
12 upon appropriate filing under such procedure in connec-
13 tion with plans in such class and payment of the pre-
14 scribed fee under section 807(a).
15 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
16 HEALTH PLANS.—An association health plan which offers
17 one or more benefit options which do not consist of health
18 insurance coverage may be certified under this part only
19 if such plan consists of any of the following:
20 “(1) a plan which offered such coverage on the
21 date of the enactment of the Quality Care for the
22 Uninsured Act of 1999,
23 “(2) a plan under which the sponsor does not
24 restrict membership to one or more trades and busi-
25 nesses or industries and whose eligible participating

1 employers represent a broad cross-section of trades
2 and businesses or industries, or

3 ‘‘(3) a plan whose eligible participating employ-
4 ers represent one or more trades or businesses, or
5 one or more industries, which have been indicated as
6 having average or above-average health insurance
7 risk or health claims experience by reason of State
8 rate filings, denials of coverage, proposed premium
9 rate levels, and other means demonstrated by such
10 plan in accordance with regulations which the Sec-
11 retary shall prescribe through negotiated rule-
12 making, including (but not limited to) the following:
13 agriculture; automobile dealerships; barbering and
14 cosmetology; child care; construction; dance, theat-
15 rical, and orchestra productions; disinfecting and
16 pest control; eating and drinking establishments;
17 fishing; hospitals; labor organizations; logging; man-
18 ufacturing (metals); mining; medical and dental
19 practices; medical laboratories; sanitary services;
20 transportation (local and freight); and warehousing.

21 **‘‘SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
22 **BOARDS OF TRUSTEES.**

23 ‘‘(a) SPONSOR.—The requirements of this subsection
24 are met with respect to an association health plan if the
25 sponsor has met (or is deemed under this part to have

1 met) the requirements of section 801(b) for a continuous
2 period of not less than 3 years ending with the date of
3 the application for certification under this part.

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

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

12 ‘‘(2) RULES OF OPERATION AND FINANCIAL
13 CONTROLS.—The board of trustees has in effect
14 rules of operation and financial controls, based on a
15 3-year plan of operation, adequate to carry out the
16 terms of the plan and to meet all requirements of
17 this title applicable to the plan.

18 ‘‘(3) RULES GOVERNING RELATIONSHIP TO
19 PARTICIPATING EMPLOYERS AND TO CONTRAC-
20 TORS.—

21 ‘‘(A) IN GENERAL.—Except as provided in
22 subparagraphs (B) and (C), the members of the
23 board of trustees are individuals selected from
24 individuals who are the owners, officers, direc-
25 tors, or employees of the participating employ-

1 ers or who are partners in the participating em-
2 ployers and actively participate in the business.
3 "(B) LIMITATION.—
4 "(i) GENERAL RULE.—Except as pro-
5 vided in clauses (ii) and (iii), no such
6 member is an owner, officer, director, or
7 employee of, or partner in, a contract ad-
8 ministrator or other service provider to the
9 plan.
10 "(ii) LIMITED EXCEPTION FOR PRO-
11 VIDERS OF SERVICES SOLELY ON BEHALF
12 OF THE SPONSOR.—Officers or employees
13 of a sponsor which is a service provider
14 (other than a contract administrator) to
15 the plan may be members of the board if
16 they constitute not more than 25 percent
17 of the membership of the board and they
18 do not provide services to the plan other
19 than on behalf of the sponsor.
20 "(iii) TREATMENT OF PROVIDERS OF
21 MEDICAL CARE.—In the case of a sponsor
22 which is an association whose membership
23 consists primarily of providers of medical
24 care, clause (i) shall not apply in the case
25 of any service provider described in sub-

1 paragraph (A) who is a provider of medical
2 care under the plan.
3 "(C) CERTAIN PLANS EXCLUDED.—Sub-
4 paragraph (A) shall not apply to an association
5 health plan which is in existence on the date of
6 the enactment of the Quality Care for the Unin-
7 sured Act of 1999.
8 "(D) SOLE AUTHORITY.—The board has
9 sole authority under the plan to approve appli-
10 cations for participation in the plan and to con-
11 tract with a service provider to administer the
12 day-to-day affairs of the plan.
13 "(c) TREATMENT OF FRANCHISE NETWORKS.—In
14 the case of a group health plan which is established and
15 maintained by a franchiser for a franchise network con-
16 sisting of its franchisees—
17 "(1) the requirements of subsection (a) and sec-
18 tion 801(a)(1) shall be deemed met if such require-
19 ments would otherwise be met if the franchiser were
20 deemed to be the sponsor referred to in section
21 801(b), such network were deemed to be an associa-
22 tion described in section 801(b), and each franchisee
23 were deemed to be a member (of the association and
24 the sponsor) referred to in section 801(b); and

1 "(2) the requirements of section 804(a)(1) shall
2 be deemed met.
3 The Secretary may by regulation, through negotiated rule-
4 making, define for purposes of this subsection the terms
5 'franchiser', 'franchise network', and 'franchisee'.
6 "(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—
7 "(1) IN GENERAL.—In the case of a group
8 health plan described in paragraph (2)—
9 "(A) the requirements of subsection (a)
10 and section 801(a)(1) shall be deemed met;
11 "(B) the joint board of trustees shall be
12 deemed a board of trustees with respect to
13 which the requirements of subsection (b) are
14 met; and
15 "(C) the requirements of section 804 shall
16 be deemed met.
17 "(2) REQUIREMENTS.—A group health plan is
18 described in this paragraph if—
19 "(A) the plan is a multiemployer plan; or
20 "(B) the plan is in existence on April 1,
21 1997, and would be described in section
22 3(40)(A)(i) but solely for the failure to meet
23 the requirements of section 3(40)(C)(ii).

1 **"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-
2 MENTS.**

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

7 ''(1) each participating employer must be—

8 ''(A) a member of the sponsor,

9 ''(B) the sponsor, or

10 ''(C) an affiliated member of the sponsor
11 with respect to which the requirements of sub-
12 section (b) are met,

13 except that, in the case of a sponsor which is a pro-
14 fessional association or other individual-based asso-
15 ciation, if at least one of the officers, directors, or
16 employees of an employer, or at least one of the in-
17 dividuals who are partners in an employer and who
18 actively participates in the business, is a member or
19 such an affiliated member of the sponsor, partici-
20 pating employers may also include such employer;
21 and

22 ''(2) all individuals commencing coverage under
23 the plan after certification under this part must
24 be—

25 ''(A) active or retired owners (including
26 self-employed individuals), officers, directors, or

1 employees of, or partners in, participating em-
2 ployers; or
3 "(B) the beneficiaries of individuals de-
4 scribed in subparagraph (A).
5 "(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
6 PLOYEES.—In the case of an association health plan in
7 existence on the date of the enactment of the Quality Care
8 for the Uninsured Act of 1999, an affiliated member of
9 the sponsor of the plan may be offered coverage under
10 the plan as a participating employer only if—
11 "(1) the affiliated member was an affiliated
12 member on the date of certification under this part;
13 or
14 "(2) during the 12-month period preceding the
15 date of the offering of such coverage, the affiliated
16 member has not maintained or contributed to a
17 group health plan with respect to any of its employ-
18 ees who would otherwise be eligible to participate in
19 such association health plan.
20 "(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
21 quirements of this subsection are met with respect to an
22 association health plan if, under the terms of the plan,
23 no participating employer may provide health insurance
24 coverage in the individual market for any employee not
25 covered under the plan which is similar to the coverage

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.

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

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

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

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

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

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

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

24 ‘‘(A) The contribution rates for any par-
25 ticipating small employer do not vary on the
26 basis of the claims experience of such employer

1 and do not vary on the basis of the type of
2 business or industry in which such employer is
3 engaged.

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

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

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

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

24 ''(3) FLOOR FOR NUMBER OF COVERED INDI-
25 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If

1 any benefit option under the plan does not consist
2 of health insurance coverage, the plan has as of the
3 beginning of the plan year not fewer than 1,000 par-
4 ticipants and beneficiaries.

5 ‘‘(4) MARKETING REQUIREMENTS.—

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

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

23 ‘‘(5) REGULATORY REQUIREMENTS.—Such
24 other requirements as the applicable authority deter-
25 mines are necessary to carry out the purposes of this

1 part, which shall be prescribed by the applicable au-
2 thority by regulation through negotiated rulemaking.
3 "(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
4 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
5 nothing in this part or any provision of State law (as de-
6 fined in section 514(c)(1)) shall be construed to preclude
7 an association health plan, or a health insurance issuer
8 offering health insurance coverage in connection with an
9 association health plan, from exercising its sole discretion
10 in selecting the specific items and services consisting of
11 medical care to be included as benefits under such plan
12 or coverage, except (subject to section 514) in the case
13 of any law to the extent that it (1) prohibits an exclusion
14 of a specific disease from such coverage, or (2) is not pre-
15 empted under section 731(a)(1) with respect to matters
16 governed by section 711 or 712.

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

21 "(a) IN GENERAL.—The requirements of this section
22 are met with respect to an association health plan if—
23 "(1) the benefits under the plan consist solely
24 of health insurance coverage; or

1 "(2) if the plan provides any additional benefit
2 options which do not consist of health insurance cov-
3 erage, the plan—
4 "(A) establishes and maintains reserves
5 with respect to such additional benefit options,
6 in amounts recommended by the qualified actu-
7 ary, consisting of—
8 "(i) a reserve sufficient for unearned
9 contributions;
10 "(ii) a reserve sufficient for benefit li-
11 abilities which have been incurred, which
12 have not been satisfied, and for which risk
13 of loss has not yet been transferred, and
14 for expected administrative costs with re-
15 spect to such benefit liabilities;
16 "(iii) a reserve sufficient for any other
17 obligations of the plan; and
18 "(iv) a reserve sufficient for a margin
19 of error and other fluctuations, taking into
20 account the specific circumstances of the
21 plan; and
22 "(B) establishes and maintains aggregate
23 and specific excess/stop loss insurance and sol-
24 vency indemnification, with respect to such ad-

1 ditional benefit options for which risk of loss
2 has not yet been transferred, as follows:
3 ''(i) The plan shall secure aggregate
4 excess/stop loss insurance for the plan
5 with an attachment point which is not
6 greater than 125 percent of expected gross
7 annual claims. The applicable authority
8 may by regulation, through negotiated
9 rulemaking, provide for upward adjust-
10 ments in the amount of such percentage in
11 specified circumstances in which the plan
12 specifically provides for and maintains re-
13 serves in excess of the amounts required
14 under subparagraph (A).
15 ''(ii) The plan shall secure specific ex-
16 cess/stop loss insurance for the plan with
17 an attachment point which is at least equal
18 to an amount recommended by the plan's
19 qualified actuary (but not more than
20 $175,000). The applicable authority may
21 by regulation, through negotiated rule-
22 making, provide for adjustments in the
23 amount of such insurance in specified cir-
24 cumstances in which the plan specifically
25 provides for and maintains reserves in ex-

1 cess of the amounts required under sub-
2 paragraph (A).
3 "(iii) The plan shall secure indem-
4 nification insurance for any claims which
5 the plan is unable to satisfy by reason of
6 a plan termination.
7 Any regulations prescribed by the applicable authority
8 pursuant to clause (i) or (ii) of subparagraph (B) may
9 allow for such adjustments in the required levels of excess/
10 stop loss insurance as the qualified actuary may rec-
11 ommend, taking into account the specific circumstances
12 of the plan.
13 "(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
14 RESERVES.—In the case of any association health plan de-
15 scribed in subsection (a)(2), the requirements of this sub-
16 section are met if the plan establishes and maintains sur-
17 plus in an amount at least equal to—
18 "(1) $500,000, or
19 "(2) such greater amount (but not greater than
20 $2,000,000) as may be set forth in regulations pre-
21 scribed by the applicable authority through nego-
22 tiated rulemaking, based on the level of aggregate
23 and specific excess/stop loss insurance provided with
24 respect to such plan.

1 "(c) ADDITIONAL REQUIREMENTS.—In the case of
2 any association health plan described in subsection (a)(2),
3 the applicable authority may provide such additional re-
4 quirements relating to reserves and excess/stop loss insur-
5 ance as the applicable authority considers appropriate.
6 Such requirements may be provided by regulation, through
7 negotiated rulemaking, with respect to any such plan or
8 any class of such plans.

9 "(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
10 ANCE.—The applicable authority may provide for adjust-
11 ments to the levels of reserves otherwise required under
12 subsections (a) and (b) with respect to any plan or class
13 of plans to take into account excess/stop loss insurance
14 provided with respect to such plan or plans.

15 "(e) ALTERNATIVE MEANS OF COMPLIANCE.—The
16 applicable authority may permit an association health plan
17 described in subsection (a)(2) to substitute, for all or part
18 of the requirements of this section (except subsection
19 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
20 rangement, or other financial arrangement as the applica-
21 ble authority determines to be adequate to enable the plan
22 to fully meet all its financial obligations on a timely basis
23 and is otherwise no less protective of the interests of par-
24 ticipants and beneficiaries than the requirements for
25 which it is substituted. The applicable authority may take

1 into account, for purposes of this subsection, evidence pro-
2 vided by the plan or sponsor which demonstrates an as-
3 sumption of liability with respect to the plan. Such evi-
4 dence may be in the form of a contract of indemnification,
5 lien, bonding, insurance, letter of credit, recourse under
6 applicable terms of the plan in the form of assessments
7 of participating employers, security, or other financial ar-
8 rangement.

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

11 ‘‘(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
12 CIATION HEALTH PLAN FUND.—

13 ‘‘(A) IN GENERAL.—In the case of an as-
14 sociation health plan described in subsection
15 (a)(2), the requirements of this subsection are
16 met if the plan makes payments into the Asso-
17 ciation Health Plan Fund under this subpara-
18 graph when they are due. Such payments shall
19 consist of annual payments in the amount of
20 $5,000, except that the Secretary shall reduce
21 part or all of such annual payments, or shall
22 provide a rebate of part or all of such a pay-
23 ment, to the extent that the Secretary deter-
24 mines that the balance in such Fund is suffi-
25 cient (taking into account such a reduction or

1 rebate) to meet all reasonable actuarial require-
2 ments. Such determination shall occur not less
3 than once annually. In addition to any such an-
4 nual payments, such payments may include
5 such supplemental payments as the Secretary
6 may determine to be necessary to meet reason-
7 able actuarial requirements to carry out para-
8 graph (2). Payments under this paragraph are
9 payable to the Fund at the time determined by
10 the Secretary. Initial payments are due in ad-
11 vance of certification under this part. Payments
12 shall continue to accrue until a plan's assets are
13 distributed pursuant to a termination proce-
14 dure.

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

21 "(C) CONTINUED DUTY OF THE SEC-
22 RETARY.—The Secretary shall not cease to
23 carry out the provisions of paragraph (2) on ac-
24 count of the failure of a plan to pay any pay-
25 ment when due.

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

1 "(A) IN GENERAL.—There is established
2 on the books of the Treasury a fund to be
3 known as the 'Association Health Plan Fund'.
4 The Fund shall be available for making pay-
5 ments pursuant to paragraph (2). The Fund
6 shall be credited with payments received pursu-
7 ant to paragraph (1)(A), penalties received pur-
8 suant to paragraph (1)(B); and earnings on in-
9 vestments of amounts of the Fund under sub-
10 paragraph (B).
11 "(B) INVESTMENT.—Whenever the Sec-
12 retary determines that the moneys of the fund
13 are in excess of current needs, the Secretary
14 may request the investment of such amounts as
15 the Secretary determines advisable by the Sec-
16 retary of the Treasury in obligations issued or
17 guaranteed by the United States.
18 "(g) EXCESS/STOP LOSS INSURANCE.—For pur-
19 poses of this section—
20 "(1) AGGREGATE EXCESS/STOP LOSS INSUR-
21 ANCE.—The term 'aggregate excess/stop loss insur-
22 ance' means, in connection with an association
23 health plan, a contract—
24 "(A) under which an insurer (meeting such
25 minimum standards as the applicable authority may

1 prescribe by regulation through negotiated rule-
2 making) provides for payment to the plan with re-
3 spect to aggregate claims under the plan in excess
4 of an amount or amounts specified in such contract;
5 ''(B) which is guaranteed renewable; and
6 ''(C) which allows for payment of premiums by
7 any third party on behalf of the insured plan.
8 ''(2) SPECIFIC EXCESS/STOP LOSS INSUR-
9 ANCE.—The term 'specific excess/stop loss insur-
10 ance' means, in connection with an association
11 health plan, a contract—
12 ''(A) under which an insurer (meeting such
13 minimum standards as the applicable authority
14 may prescribe by regulation through negotiated
15 rulemaking) provides for payment to the plan
16 with respect to claims under the plan in connec-
17 tion with a covered individual in excess of an
18 amount or amounts specified in such contract
19 in connection with such covered individual;
20 ''(B) which is guaranteed renewable; and
21 ''(C) which allows for payment of pre-
22 miums by any third party on behalf of the in-
23 sured plan.
24 ''(h) INDEMNIFICATION INSURANCE.—For purposes
25 of this section, the term 'indemnification insurance'

1 means, in connection with an association health plan, a
2 contract—

3 "(1) under which an insurer (meeting such min-
4 imum standards as the applicable authority may pre-
5 scribe through negotiated rulemaking) provides for
6 payment to the plan with respect to claims under the
7 plan which the plan is unable to satisfy by reason
8 of a termination pursuant to section 809(b) (relating
9 to mandatory termination);

10 "(2) which is guaranteed renewable and
11 noncancellable for any reason (except as the applica-
12 ble authority may prescribe by regulation through
13 negotiated rulemaking); and

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

16 "(i) RESERVES.—For purposes of this section, the
17 term 'reserves' means, in connection with an association
18 health plan, plan assets which meet the fiduciary stand-
19 ards under part 4 and such additional requirements re-
20 garding liquidity as the applicable authority may prescribe
21 through negotiated rulemaking.

22 "(j) SOLVENCY STANDARDS WORKING GROUP.—

23 "(1) IN GENERAL.—Within 90 days after the
24 date of the enactment of the Quality Care for the
25 Uninsured Act of 1999, the applicable authority

1 shall establish a Solvency Standards Working
2 Group. In prescribing the initial regulations under
3 this section, the applicable authority shall take into
4 account the recommendations of such Working
5 Group.

6 "(2) MEMBERSHIP.—The Working Group shall
7 consist of 18 members appointed by the applicable
8 authority as follows:

9 "(A) 3 representatives of the National As-
10 sociation of Insurance Commissioners;

11 "(B) 3 representatives of the American
12 Academy of Actuaries;

13 "(C) 3 representatives of the State govern-
14 ments, or their interests;

15 "(D) 3 representatives of existing self-in-
16 sured arrangements, or their interests;

17 "(E) 3 representatives of associations of
18 the type referred to in section 801(b)(1), or
19 their interests; and

20 "(F) 3 representatives of multiemployer
21 plans that are group health plans, or their in-
22 terests.

1 **"SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
2 **LATED REQUIREMENTS.**

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

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

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

20 "(A) the sponsor; and

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

23 "(2) STATES IN WHICH PLAN INTENDS TO DO
24 BUSINESS.—The States in which participants and
25 beneficiaries under the plan are to be located and

1 the number of them expected to be located in each
2 such State.

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

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

14 "(5) AGREEMENTS WITH SERVICE PRO-
15 VIDERS.—A copy of any agreements between the
16 plan and contract administrators and other service
17 providers.

18 "(6) FUNDING REPORT.—In the case of asso-
19 ciation health plans providing benefits options in ad-
20 dition to health insurance coverage, a report setting
21 forth information with respect to such additional
22 benefit options determined as of a date within the
23 120-day period ending with the date of the applica-
24 tion, including the following:

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

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

23 "(C) CURRENT AND PROJECTED VALUE OF
24 ASSETS AND LIABILITIES.—A statement of ac-
25 tuarial opinion signed by a qualified actuary,

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

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

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

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

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

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

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

plicable authority may require by regulation through negotiated rulemaking 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—

"(1) not less than 60 days before the proposed termination date, 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 through negotiated rulemaking.

"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 re-

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

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

1 ''(b) POWERS AS TRUSTEE.—The Secretary, upon
2 appointment as trustee under subsection (a), shall have
3 the power—
4 ''(1) to do any act authorized by the plan, this
5 title, or other applicable provisions of law to be done
6 by the plan administrator or any trustee of the plan;
7 ''(2) to require the transfer of all (or any part)
8 of the assets and records of the plan to the Sec-
9 retary as trustee;
10 ''(3) to invest any assets of the plan which the
11 Secretary holds in accordance with the provisions of
12 the plan, regulations prescribed by the Secretary
13 through negotiated rulemaking, and applicable provi-
14 sions of law;
15 ''(4) to require the sponsor, the plan adminis-
16 trator, any participating employer, and any employee
17 organization representing plan participants to fur-
18 nish any information with respect to the plan which
19 the Secretary as trustee may reasonably need in
20 order to administer the plan;
21 ''(5) to collect for the plan any amounts due the
22 plan and to recover reasonable expenses of the trust-
23 eeship;

1 ‘‘(6) to commence, prosecute, or defend on be-
2 half of the plan any suit or proceeding involving the
3 plan;
4 ‘‘(7) to issue, publish, or file such notices, state-
5 ments, and reports as may be required by the Sec-
6 retary by regulation through negotiated rulemaking
7 or required by any order of the court;
8 ‘‘(8) to terminate the plan (or provide for its
9 termination accordance with section 809(b)) and liq-
10 uidate the plan assets, to restore the plan to the re-
11 sponsibility of the sponsor, or to continue the trust-
12 eeship;
13 ‘‘(9) to provide for the enrollment of plan par-
14 ticipants and beneficiaries under appropriate cov-
15 erage options; and
16 ‘‘(10) to do such other acts as may be nec-
17 essary to comply with this title or any order of the
18 court and to protect the interests of plan partici-
19 pants and beneficiaries and providers of medical
20 care.
21 ‘‘(c) NOTICE OF APPOINTMENT.—As soon as prac-
22 ticable after the Secretary’s appointment as trustee, the
23 Secretary shall give notice of such appointment to—
24 ‘‘(1) the sponsor and plan administrator;
25 ‘‘(2) each participant;

1 "(3) each participating employer; and
2 "(4) if applicable, each employee organization
3 which, for purposes of collective bargaining, rep-
4 resents plan participants.
5 "(d) ADDITIONAL DUTIES.—Except to the extent in-
6 consistent with the provisions of this title, or as may be
7 otherwise ordered by the court, the Secretary, upon ap-
8 pointment as trustee under this section, shall be subject
9 to the same duties as those of a trustee under section 704
10 of title 11, United States Code, and shall have the duties
11 of a fiduciary for purposes of this title.
12 "(e) OTHER PROCEEDINGS.—An application by the
13 Secretary under this subsection may be filed notwith-
14 standing the pendency in the same or any other court of
15 any bankruptcy, mortgage foreclosure, or equity receiver-
16 ship proceeding, or any proceeding to reorganize, conserve,
17 or liquidate such plan or its property, or any proceeding
18 to enforce a lien against property of the plan.
19 "(f) JURISDICTION OF COURT.—
20 "(1) IN GENERAL.—Upon the filing of an appli-
21 cation for the appointment as trustee or the issuance
22 of a decree under this section, the court to which the
23 application is made shall have exclusive jurisdiction
24 of the plan involved and its property wherever lo-
25 cated with the powers, to the extent consistent with

1 the purposes of this section, of a court of the United
2 States having jurisdiction over cases under chapter
3 11 of title 11, United States Code. Pending an adju-
4 dication under this section such court shall stay, and
5 upon appointment by it of the Secretary as trustee,
6 such court shall continue the stay of, any pending
7 mortgage foreclosure, equity receivership, or other
8 proceeding to reorganize, conserve, or liquidate the
9 plan, the sponsor, or property of such plan or spon-
10 sor, and any other suit against any receiver, conser-
11 vator, or trustee of the plan, the sponsor, or prop-
12 erty of the plan or sponsor. Pending such adjudica-
13 tion and upon the appointment by it of the Sec-
14 retary as trustee, the court may stay any proceeding
15 to enforce a lien against property of the plan or the
16 sponsor or any other suit against the plan or the
17 sponsor.

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

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

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

8 ''(a) IN GENERAL.—Notwithstanding section 514, a
9 State may impose by law a contribution tax on an associa-
10 tion health plan described in section 806(a)(2), if the plan
11 commenced operations in such State after the date of the
12 enactment of the Quality Care for the Uninsured Act of
13 1999.

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

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

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

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

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

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

19 **"SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

20 "(a) ELECTION FOR CHURCH PLANS.—Notwith-
21 standing section 4(b)(2), if a church, a convention or asso-
22 ciation of churches, or an organization described in section
23 3(33)(C)(i) maintains a church plan which is a group
24 health plan (as defined in section 733(a)(1)), and such
25 church, convention, association, or organization makes an

1 election with respect to such plan under this subsection
2 (in such form and manner as the Secretary may by regula-
3 tion prescribe), then the provisions of this section shall
4 apply to such plan, with respect to benefits provided under
5 such plan consisting of medical care, as if section 4(b)(2)
6 did not contain an exclusion for church plans. Nothing in
7 this subsection shall be construed to render any other sec-
8 tion of this title applicable to church plans, except to the
9 extent that such other section is incorporated by reference
10 in this section.

11 ''(b) EFFECT OF ELECTION.—

12 ''(1) PREEMPTION OF STATE INSURANCE LAWS
13 REGULATING COVERED CHURCH PLANS.—Subject to
14 paragraphs (2) and (3), this section shall supersede
15 any and all State laws which regulate insurance in-
16 sofar as they may now or hereafter regulate church
17 plans to which this section applies or trusts estab-
18 lished under such church plans.

19 ''(2) GENERAL STATE INSURANCE REGULATION
20 UNAFFECTED.—

21 ''(A) IN GENERAL.—Except as provided in
22 subparagraph (B) and paragraph (3), nothing
23 in this section shall be construed to exempt or
24 relieve any person from any provision of State
25 law which regulates insurance.

1 "(B) CHURCH PLANS NOT TO BE DEEMED
2 INSURANCE COMPANIES OR INSURERS.—Neither
3 a church plan to which this section applies, nor
4 any trust established under such a church plan,
5 shall be deemed to be an insurance company or
6 other insurer or to be engaged in the business
7 of insurance for purposes of any State law pur-
8 porting to regulate insurance companies or in-
9 surance contracts.
10 "(3) PREEMPTION OF CERTAIN STATE LAWS
11 RELATING TO PREMIUM RATE REGULATION AND
12 BENEFIT MANDATES.—The provisions of subsections
13 (a)(2)(B) and (b) of section 805 shall apply with re-
14 spect to a church plan to which this section applies
15 in the same manner and to the same extent as such
16 provisions apply with respect to association health
17 plans.
18 "(4) DEFINITIONS.—For purposes of this
19 subsection—
20 "(A) STATE LAW.—The term 'State law'
21 includes all laws, decisions, rules, regulations,
22 or other State action having the effect of law,
23 of any State. A law of the United States appli-
24 cable only to the District of Columbia shall be

1 treated as a State law rather than a law of the
2 United States.
3 ‘‘(B) STATE.—The term ‘State’ includes a
4 State, any political subdivision thereof, or any
5 agency or instrumentality of either, which pur-
6 ports to regulate, directly or indirectly, the
7 terms and conditions of church plans covered by
8 this section.
9 ‘‘(c) REQUIREMENTS FOR COVERED CHURCH
10 PLANS.—
11 ‘‘(1) FIDUCIARY RULES AND EXCLUSIVE PUR-
12 POSE.—A fiduciary shall discharge his duties with
13 respect to a church plan to which this section
14 applies—
15 ‘‘(A) for the exclusive purpose of:
16 ‘‘(i) providing benefits to participants
17 and their beneficiaries; and
18 ‘‘(ii) defraying reasonable expenses of
19 administering the plan;
20 ‘‘(B) with the care, skill, prudence and dili-
21 gence under the circumstances then prevailing
22 that a prudent man acting in a like capacity
23 and familiar with such matters would use in the
24 conduct of an enterprise of a like character and
25 with like aims; and

1 “(C) in accordance with the documents
2 and instruments governing the plan.
3 The requirements of this paragraph shall not be
4 treated as not satisfied solely because the plan as-
5 sets are commingled with other church assets, to the
6 extent that such plan assets are separately ac-
7 counted for.
8 “(2) CLAIMS PROCEDURE.—In accordance with
9 regulations of the Secretary, every church plan to
10 which this section applies shall—
11 “(A) provide adequate notice in writing to
12 any participant or beneficiary whose claim for
13 benefits under the plan has been denied, setting
14 forth the specific reasons for such denial, writ-
15 ten in a manner calculated to be understood by
16 the participant;
17 “(B) afford a reasonable opportunity to
18 any participant whose claim for benefits has
19 been denied for a full and fair review by the ap-
20 propriate fiduciary of the decision denying the
21 claim; and
22 “(C) provide a written statement to each
23 participant describing the procedures estab-
24 lished pursuant to this paragraph.

1 "(3) ANNUAL STATEMENTS.—In accordance
2 with regulations of the Secretary, every church plan
3 to which this section applies shall file with the Sec-
4 retary an annual statement—
5 "(A) stating the names and addresses of
6 the plan and of the church, convention, or asso-
7 ciation maintaining the plan (and its principal
8 place of business);
9 "(B) certifying that it is a church plan to
10 which this section applies and that it complies
11 with the requirements of paragraphs (1) and
12 (2);
13 "(C) identifying the States in which par-
14 ticipants and beneficiaries under the plan are or
15 likely will be located during the 1-year period
16 covered by the statement; and
17 "(D) containing a copy of a statement of
18 actuarial opinion signed by a qualified actuary
19 that the plan maintains capital, reserves, insur-
20 ance, other financial arrangements, or any com-
21 bination thereof adequate to enable the plan to
22 fully meet all of its financial obligations on a
23 timely basis.
24 "(4) DISCLOSURE.—At the time that the an-
25 nual statement is filed by a church plan with the

1 Secretary pursuant to paragraph (3), a copy of such
2 statement shall be made available by the Secretary
3 to the State insurance commissioner (or similar offi-
4 cial) of any State. The name of each church plan
5 and sponsoring organization filing an annual state-
6 ment in compliance with paragraph (3) shall be pub-
7 lished annually in the Federal Register.

8 ''(c) ENFORCEMENT.—The Secretary may enforce
9 the provisions of this section in a manner consistent with
10 section 502, to the extent applicable with respect to ac-
11 tions under section 502(a)(5), and with section 3(33)(D),
12 except that, other than for the purpose of seeking a tem-
13 porary restraining order, a civil action may be brought
14 with respect to the plan's failure to meet any requirement
15 of this section only if the plan fails to correct its failure
16 within the correction period described in section 3(33)(D).
17 The other provisions of part 5 (except sections 501(a),
18 503, 512, 514, and 515) shall apply with respect to the
19 enforcement and administration of this section.

20 ''(d) DEFINITIONS AND OTHER RULES.—For pur-
21 poses of this section—

22 ''(1) IN GENERAL.—Except as otherwise pro-
23 vided in this section, any term used in this section
24 which is defined in any provision of this title shall

1 have the definition provided such term by such pro-
2 vision.

3 "(2) SEMINARY STUDENTS.—Seminary students
4 who are enrolled in an institution of higher learning
5 described in section 3(33)(C)(iv) and who are treat-
6 ed as participants under the terms of a church plan
7 to which this section applies shall be deemed to be
8 employees as defined in section 3(6) if the number
9 of such students constitutes an insignificant portion
10 of the total number of individuals who are treated
11 as participants under the terms of the plan.

12 **"SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

14 "(1) GROUP HEALTH PLAN.—The term 'group
15 health plan' has the meaning provided in section
16 733(a)(1) (after applying subsection (b) of this sec-
17 tion).

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

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

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

1 ‘‘(5) APPLICABLE AUTHORITY.—
2 ‘‘(A) IN GENERAL.—Except as provided in
3 subparagraph (B), the term ‘applicable author-
4 ity’ means, in connection with an association
5 health plan—
6 ‘‘(i) the State recognized pursuant to
7 subsection (c) of section 506 as the State
8 to which authority has been delegated in
9 connection with such plan; or
10 ‘‘(ii) if there is no State referred to in
11 clause (i), the Secretary.
12 ‘‘(B) EXCEPTIONS.—
13 ‘‘(i) JOINT AUTHORITIES.—Where
14 such term appears in section 808(3), sec-
15 tion 807(e) (in the first instance), section
16 809(a) (in the second instance), section
17 809(a) (in the fourth instance), and sec-
18 tion 809(b)(1), such term means, in con-
19 nection with an association health plan, the
20 Secretary and the State referred to in sub-
21 paragraph (A)(i) (if any) in connection
22 with such plan.
23 ‘‘(ii) REGULATORY AUTHORITIES.—
24 Where such term appears in section 802(a)
25 (in the first instance), section 802(d), sec-

tion 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 806(j), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

"(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

1 connection with a group health plan that
2 has fewer than 2 participants as current
3 employees or participants described in sec-
4 tion 732(d)(3) on the first day of the plan
5 year.

6 "(ii) STATE EXCEPTION.—Clause (i)
7 shall not apply in the case of health insur-
8 ance coverage offered in a State if such
9 State regulates the coverage described in
10 such clause in the same manner and to the
11 same extent as coverage in the small group
12 market (as defined in section 2791(e)(5) of
13 the Public Health Service Act) is regulated
14 by such State.

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

1 "(9) APPLICABLE STATE AUTHORITY.—The
2 term 'applicable State authority' means, with respect
3 to a health insurance issuer in a State, the State in-
4 surance commissioner or official or officials des-
5 ignated by the State to enforce the requirements of
6 title XXVII of the Public Health Service Act for the
7 State involved with respect to such issuer.
8 "(10) QUALIFIED ACTUARY.—The term 'quali-
9 fied actuary' means an individual who is a member
10 of the American Academy of Actuaries or meets
11 such reasonable standards and qualifications as the
12 Secretary may provide by regulation through nego-
13 tiated rulemaking.
14 "(11) AFFILIATED MEMBER.—The term 'affili-
15 ated member' means, in connection with a sponsor—
16 "(A) a person who is otherwise eligible to
17 be a member of the sponsor but who elects an
18 affiliated status with the sponsor,
19 "(B) in the case of a sponsor with mem-
20 bers which consist of associations, a person who
21 is a member of any such association and elects
22 an affiliated status with the sponsor, or
23 "(C) in the case of an association health
24 plan in existence on the date of the enactment
25 of the Quality Care for the Uninsured Act of

1 1999, a person eligible to be a member of the
2 sponsor or one of its member associations.
3 "(12) LARGE EMPLOYER.—The term 'large em-
4 ployer' means, in connection with a group health
5 plan with respect to a plan year, an employer who
6 employed an average of at least 51 employees on
7 business days during the preceding calendar year
8 and who employs at least 2 employees on the first
9 day of the plan year.
10 "(13) SMALL EMPLOYER.—The term 'small em-
11 ployer' means, in connection with a group health
12 plan with respect to a plan year, an employer who
13 is not a large employer.
14 "(b) RULES OF CONSTRUCTION.—
15 "(1) EMPLOYERS AND EMPLOYEES.—For pur-
16 poses of determining whether a plan, fund, or pro-
17 gram is an employee welfare benefit plan which is an
18 association health plan, and for purposes of applying
19 this title in connection with such plan, fund, or pro-
20 gram so determined to be such an employee welfare
21 benefit plan—
22 "(A) in the case of a partnership, the term
23 'employer' (as defined in section (3)(5)) in-
24 cludes the partnership in relation to the part-
25 ners, and the term 'employee' (as defined in

1 section (3)(6)) includes any partner in relation
2 to the partnership; and

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

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

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

23 (1) Section 514(b)(6) of such Act (29 U.S.C.
24 1144(b)(6)) is amended by adding at the end the
25 following new subparagraph:

1 "(E) The preceding subparagraphs of this paragraph
2 do not apply with respect to any State law in the case
3 of an association health plan which is certified under part
4 8.".
5 (2) Section 514 of such Act (29 U.S.C. 1144)
6 is amended—
7 (A) in subsection (b)(4), by striking "Sub-
8 section (a)" and inserting "Subsections (a) and
9 (d)";
10 (B) in subsection (b)(5), by striking "sub-
11 section (a)" in subparagraph (A) and inserting
12 "subsection (a) of this section and subsections
13 (a)(2)(B) and (b) of section 805", and by strik-
14 ing "subsection (a)" in subparagraph (B) and
15 inserting "subsection (a) of this section or sub-
16 section (a)(2)(B) or (b) of section 805";
17 (C) by redesignating subsection (d) as sub-
18 section (e); and
19 (D) by inserting after subsection (c) the
20 following new subsection:
21 "(d)(1) Except as provided in subsection (b)(4), the
22 provisions of this title shall supersede any and all State
23 laws insofar as they may now or hereafter preclude, or
24 have the effect of precluding, a health insurance issuer
25 from offering health insurance coverage in connection with

1 an association health plan which is certified under part
2 8.

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

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

17 ''(B) In any case in which health insurance cov-
18 erage of any policy type is offered under an associa-
19 tion health plan in a State and the filing, with the
20 applicable State authority, of the policy form in con-
21 nection with such policy type is approved by such
22 State authority, the provisions of this title shall su-
23 persede any and all laws of any other State in which
24 health insurance coverage of such type is offered, in-
25 sofar as they may preclude, upon the filing in the

1 same form and manner of such policy form with the
2 applicable State authority in such other State, the
3 approval of the filing in such other State.

4 ''(3) For additional provisions relating to association
5 health plans, see subsections (a)(2)(B) and (b) of section
6 805.

7 ''(4) For purposes of this subsection, the term 'asso-
8 ciation health plan' has the meaning provided in section
9 801(a), and the terms 'health insurance coverage', 'par-
10 ticipating employer', and 'health insurance issuer' have
11 the meanings provided such terms in section 811, respec-
12 tively.''.

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

15 (A) in clause (i)(II), by striking ''and'' at
16 the end;

17 (B) in clause (ii), by inserting ''and which
18 does not provide medical care (within the mean-
19 ing of section 733(a)(2)),'' after ''arrange-
20 ment,'', and by striking ''title.'' and inserting
21 ''title, and''; and

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

24 ''(iii) subject to subparagraph (E), in the case
25 of any other employee welfare benefit plan which is

1 a multiple employer welfare arrangement and which
2 provides medical care (within the meaning of section
3 733(a)(2)), any law of any State which regulates in-
4 surance may apply.''.
5 (4) Section 514(e) of such Act (as redesignated
6 by paragraph (2)(C)) is amended—
7 (A) by striking ''Nothing'' and inserting
8 ''(1) Except as provided in paragraph (2), noth-
9 ing''; and
10 (B) by adding at the end the following new
11 paragraph:
12 ''(2) Nothing in any other provision of law enacted
13 on or after the date of the enactment of the Quality Care
14 for the Uninsured Act of 1999 shall be construed to alter,
15 amend, modify, invalidate, impair, or supersede any provi-
16 sion of this title, except by specific cross-reference to the
17 affected section.''.
18 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
19 (29 U.S.C. 102(16)(B)) is amended by adding at the end
20 the following new sentence: ''Such term also includes a
21 person serving as the sponsor of an association health plan
22 under part 8.''.
23 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
24 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
25 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)

1 of such Act (29 U.S.C. 102(b)) is amended by adding at
2 the end the following: ''An association health plan shall
3 include in its summary plan description, in connection
4 with each benefit option, a description of the form of sol-
5 vency or guarantee fund protection secured pursuant to
6 this Act or applicable State law, if any.''.

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

9 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
10 CATION OF SELF-INSURED ASSOCIATION HEALTH
11 PLANS.—Not later than January 1, 2004, the Secretary
12 of Labor shall report to the Committee on Education and
13 the Workforce of the House of Representatives and the
14 Committee on Health, Education, Labor, and Pensions of
15 the Senate the effect association health plans have had,
16 if any, on reducing the number of uninsured individuals.

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

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.

"Sec. 809. Corrective actions and mandatory termination.
"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
"Sec. 811. State assessment authority.
"Sec. 812. Special rules for church plans.
"Sec. 813. Definitions and rules of construction.".

1 **SEC. 202. CLARIFICATION OF TREATMENT OF SINGLE EM-**
2 **PLOYER ARRANGEMENTS.**

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

6 (1) in clause (i), by inserting "for any plan year
7 of any such plan, or any fiscal year of any such
8 other arrangement;" after "single employer", and by
9 inserting "during such year or at any time during
10 the preceding 1-year period" after "control group";

11 (2) in clause (iii)—

12 (A) by striking "common control shall not
13 be based on an interest of less than 25 percent"
14 and inserting "an interest of greater than 25
15 percent may not be required as the minimum
16 interest necessary for common control"; and

17 (B) by striking "similar to" and inserting
18 "consistent and coextensive with";

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

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

1 "(iv) in determining, after the application of
2 clause (i), whether benefits are provided to employ-
3 ees of two or more employers, the arrangement shall
4 be treated as having only one participating employer
5 if, after the application of clause (i), the number of
6 individuals who are employees and former employees
7 of any one participating employer and who are cov-
8 ered under the arrangement is greater than 75 per-
9 cent of the aggregate number of all individuals who
10 are employees or former employees of participating
11 employers and who are covered under the arrange-
12 ment;".

13 **SEC. 203. CLARIFICATION OF TREATMENT OF CERTAIN**
14 **COLLECTIVELY BARGAINED ARRANGE-**
15 **MENTS.**

16 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-
17 ployee Retirement Income Security Act of 1974 (29
18 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

19 "(i)(I) under or pursuant to one or more collec-
20 tive bargaining agreements which are reached pursu-
21 ant to collective bargaining described in section 8(d)
22 of the National Labor Relations Act (29 U.S.C.
23 158(d)) or paragraph Fourth of section 2 of the
24 Railway Labor Act (45 U.S.C. 152, paragraph
25 Fourth) or which are reached pursuant to labor-

1 management negotiations under similar provisions of
2 State public employee relations laws, and (II) in ac-
3 cordance with subparagraphs (C), (D), and (E);''.
4 (b) LIMITATIONS.—Section 3(40) of such Act (29
5 U.S.C. 1002(40)) is amended by adding at the end the
6 following new subparagraphs:
7 ''(C) For purposes of subparagraph (A)(i)(II), a plan
8 or other arrangement shall be treated as established or
9 maintained in accordance with this subparagraph only if
10 the following requirements are met:
11 ''(i) The plan or other arrangement, and the
12 employee organization or any other entity sponsoring
13 the plan or other arrangement, do not—
14 ''(I) utilize the services of any licensed in-
15 surance agent or broker for soliciting or enroll-
16 ing employers or individuals as participating
17 employers or covered individuals under the plan
18 or other arrangement; or
19 ''(II) pay any type of compensation to a
20 person, other than a full time employee of the
21 employee organization (or a member of the or-
22 ganization to the extent provided in regulations
23 prescribed by the Secretary through negotiated
24 rulemaking), that is related either to the volume
25 or number of employers or individuals solicited

1 or enrolled as participating employers or cov-
2 ered individuals under the plan or other ar-
3 rangement, or to the dollar amount or size of
4 the contributions made by participating employ-
5 ers or covered individuals to the plan or other
6 arrangement;

7 except to the extent that the services used by the
8 plan, arrangement, organization, or other entity con-
9 sist solely of preparation of documents necessary for
10 compliance with the reporting and disclosure re-
11 quirements of part 1 or administrative, investment,
12 or consulting services unrelated to solicitation or en-
13 rollment of covered individuals.

14 ''(ii) As of the end of the preceding plan year,
15 the number of covered individuals under the plan or
16 other arrangement who are neither—

17 ''(I) employed within a bargaining unit
18 covered by any of the collective bargaining
19 agreements with a participating employer (nor
20 covered on the basis of an individual's employ-
21 ment in such a bargaining unit); nor

22 ''(II) present employees (or former employ-
23 ees who were covered while employed) of the
24 sponsoring employee organization, of an em-
25 ployer who is or was a party to any of the col-

1 lective bargaining agreements, or of the plan or
2 other arrangement or a related plan or arrange-
3 ment (nor covered on the basis of such present
4 or former employment);

5 does not exceed 15 percent of the total number of
6 individuals who are covered under the plan or ar-
7 rangement and who are present or former employees
8 who are or were covered under the plan or arrange-
9 ment pursuant to a collective bargaining agreement
10 with a participating employer. The requirements of
11 the preceding provisions of this clause shall be treat-
12 ed as satisfied if, as of the end of the preceding plan
13 year, such covered individuals are comprised solely
14 of individuals who were covered individuals under
15 the plan or other arrangement as of the date of the
16 enactment of the Quality Care for the Uninsured
17 Act of 1999 and, as of the end of the preceding plan
18 year, the number of such covered individuals does
19 not exceed 25 percent of the total number of present
20 and former employees enrolled under the plan or
21 other arrangement.

22 "(iii) The employee organization or other entity
23 sponsoring the plan or other arrangement certifies
24 to the Secretary each year, in a form and manner
25 which shall be prescribed by the Secretary through

1 negotiated rulemaking that the plan or other ar-
2 rangement meets the requirements of clauses (i) and
3 (ii).
4 ‘‘(D) For purposes of subparagraph (A)(i)(II), a plan
5 or arrangement shall be treated as established or main-
6 tained in accordance with this subparagraph only if—
7 ‘‘(i) all of the benefits provided under the plan
8 or arrangement consist of health insurance coverage;
9 or
10 ‘‘(ii)(I) the plan or arrangement is a multiem-
11 ployer plan; and
12 ‘‘(II) the requirements of clause (B) of the pro-
13 viso to clause (5) of section 302(c) of the Labor
14 Management Relations Act, 1947 (29 U.S.C.
15 186(c)) are met with respect to such plan or other
16 arrangement.
17 ‘‘(E) For purposes of subparagraph (A)(i)(II), a plan
18 or arrangement shall be treated as established or main-
19 tained in accordance with this subparagraph only if—
20 ‘‘(i) the plan or arrangement is in effect as of
21 the date of the enactment of the Quality Care for
22 the Uninsured Act of 1999; or
23 ‘‘(ii) the employee organization or other entity
24 sponsoring the plan or arrangement—

1 "(I) has been in existence for at least 3
2 years; or
3 "(II) demonstrates to the satisfaction of
4 the Secretary that the requirements of subpara-
5 graphs (C) and (D) are met with respect to the
6 plan or other arrangement.".
7 (c) CONFORMING AMENDMENTS TO DEFINITIONS OF
8 PARTICIPANT AND BENEFICIARY.—Section 3(7) of such
9 Act (29 U.S.C. 1002(7)) is amended by adding at the end
10 the following new sentence: "Such term includes an indi-
11 vidual who is a covered individual described in paragraph
12 (40)(C)(ii).".
13 **SEC. 204. ENFORCEMENT PROVISIONS.**
14 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
15 MISREPRESENTATIONS.—Section 501 of the Employee
16 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
17 is amended—
18 (1) by inserting "(a)" after "SEC. 501."; and
19 (2) by adding at the end the following new sub-
20 section:
21 "(b) Any person who willfully falsely represents, to
22 any employee, any employee's beneficiary, any employer,
23 the Secretary, or any State, a plan or other arrangement
24 established or maintained for the purpose of offering or

1 providing any benefit described in section 3(1) to employ-
2 ees or their beneficiaries as—
3 "(1) being an association health plan which has
4 been certified under part 8;
5 "(2) having been established or maintained
6 under or pursuant to one or more collective bar-
7 gaining agreements which are reached pursuant to
8 collective bargaining described in section 8(d) of the
9 National Labor Relations Act (29 U.S.C. 158(d)) or
10 paragraph Fourth of section 2 of the Railway Labor
11 Act (45 U.S.C. 152, paragraph Fourth) or which are
12 reached pursuant to labor-management negotiations
13 under similar provisions of State public employee re-
14 lations laws; or
15 "(3) being a plan or arrangement with respect
16 to which the requirements of subparagraph (C), (D),
17 or (E) of section 3(40) are met;
18 shall, upon conviction, be imprisoned not more than 5
19 years, be fined under title 18, United States Code, or
20 both.".
21 (b) CEASE ACTIVITIES ORDERS.—Section 502 of
22 such Act (29 U.S.C. 1132) is amended by adding at the
23 end the following new subsection:
24 "(n)(1) Subject to paragraph (2), upon application
25 by the Secretary showing the operation, promotion, or

1 marketing of an association health plan (or similar ar-
2 rangement providing benefits consisting of medical care
3 (as defined in section 733(a)(2))) that—

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

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

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

15 ''(2) Paragraph (1) shall not apply in the case of an
16 association health plan or other arrangement if the plan
17 or arrangement shows that—

18 ''(A) all benefits under it referred to in para-
19 graph (1) consist of health insurance coverage; and

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

"(3) 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) (as amended by title I) is amended by adding at the end the following new subsection:

"(c) 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. 205. 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:

"(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

"(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

1 "(A) the Secretary's authority under sec-
2 tions 502 and 504 to enforce the requirements
3 for certification under part 8;
4 "(B) the Secretary's authority to certify
5 association health plans under part 8 in accord-
6 ance with regulations of the Secretary applica-
7 ble to certification under part 8; or
8 "(C) any combination of the Secretary's
9 authority authorized to be delegated under sub-
10 paragraphs (A) and (B).
11 "(2) DELEGATIONS.—Any department, agency,
12 or instrumentality of a State to which authority is
13 delegated pursuant to an agreement entered into
14 under this paragraph may, if authorized under State
15 law and to the extent consistent with such agree-
16 ment, exercise the powers of the Secretary under
17 this title which relate to such authority.
18 "(3) RECOGNITION OF PRIMARY DOMICILE
19 STATE.—In entering into any agreement with a
20 State under subparagraph (A), the Secretary shall
21 ensure that, as a result of such agreement and all
22 other agreements entered into under subparagraph
23 (A), only one State will be recognized, with respect
24 to any particular association health plan, as the
25 State to which all authority has been delegated pur-

1 suant to such agreements in connection with such
2 plan. In carrying out this paragraph, the Secretary
3 shall take into account the places of residence of the
4 participants and beneficiaries under the plan and the
5 State in which the trust is maintained.''.

6 **SEC. 206. EFFECTIVE DATE AND TRANSITIONAL AND**
7 **OTHER RULES.**

8 (a) EFFECTIVE DATE.—The amendments made by
9 sections 201, 204, and 205 shall take effect on January
10 1, 2001. The amendments made by sections 202 and 203
11 shall take effect on the date of the enactment of this Act.
12 The Secretary of Labor shall first issue all regulations
13 necessary to carry out the amendments made by this title
14 before January 1, 2001. Such regulations shall be issued
15 through negotiated rulemaking.

16 (b) EXCEPTION.—Section 801(a)(2) of the Employee
17 Retirement Income Security Act of 1974 (added by section
18 201) does not apply in connection with an association
19 health plan (certified under part 8 of subtitle B of title
20 I of such Act) existing on the date of the enactment of
21 this Act, if no benefits provided thereunder as of the date
22 of the enactment of this Act consist of health insurance
23 coverage (as defined in section 733(b)(1) of such Act).

24 (c) TREATMENT OF CERTAIN EXISTING HEALTH
25 BENEFITS PROGRAMS.—

1 (1) IN GENERAL.—In any case in which, as of
2 the date of the enactment of this Act, an arrange-
3 ment is maintained in a State for the purpose of
4 providing benefits consisting of medical care for the
5 employees and beneficiaries of its participating em-
6 ployers, at least 200 participating employers make
7 contributions to such arrangement, such arrange-
8 ment has been in existence for at least 10 years, and
9 such arrangement is licensed under the laws of one
10 or more States to provide such benefits to its par-
11 ticipating employers, upon the filing with the appli-
12 cable authority (as defined in section 813(a)(5) of
13 the Employee Retirement Income Security Act of
14 1974 (as amended by this Act)) by the arrangement
15 of an application for certification of the arrangement
16 under part 8 of subtitle B of title I of such Act—
17 (A) such arrangement shall be deemed to
18 be a group health plan for purposes of title I
19 of such Act;
20 (B) the requirements of sections 801(a)(1)
21 and 803(a)(1) of the Employee Retirement In-
22 come Security Act of 1974 shall be deemed met
23 with respect to such arrangement;
24 (C) the requirements of section 803(b) of
25 such Act shall be deemed met, if the arrange-

1 ment is operated by a board of directors
2 which—
3 (i) is elected by the participating em-
4 ployers, with each employer having one
5 vote; and
6 (ii) has complete fiscal control over
7 the arrangement and which is responsible
8 for all operations of the arrangement;
9 (D) the requirements of section 804(a) of
10 such Act shall be deemed met with respect to
11 such arrangement; and
12 (E) the arrangement may be certified by
13 any applicable authority with respect to its op-
14 erations in any State only if it operates in such
15 State on the date of certification.
16 The provisions of this subsection shall cease to apply
17 with respect to any such arrangement at such time
18 after the date of the enactment of this Act as the
19 applicable requirements of this subsection are not
20 met with respect to such arrangement.
21 (2) DEFINITIONS.—For purposes of this sub-
22 section, the terms ''group health plan'', ''medical
23 care'', and ''participating employer'' shall have the
24 meanings provided in section 813 of the Employee
25 Retirement Income Security Act of 1974, except

1 that the reference in paragraph (7) of such section
2 to an ''association health plan'' shall be deemed a
3 reference to an arrangement referred to in this sub-
4 section.

5 (d) PROMOTING USE OF CERTAIN ADDITIONAL AS-
6 SOCIATIONS IN PROVIDING INDIVIDUAL HEALTH INSUR-
7 ANCE COVERAGE.—Section 2742(b)(5) of the Public
8 Health Service Act (42 U.S.C. 300gg–42(b)(5)) is
9 amended—

10 (1) by striking ''paragraph'' and inserting ''sub-
11 paragraph'';

12 (2) by inserting ''(A)'' after ''.—''; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 ''(B)(i) In the case of health insurance coverage
16 that is made available in the individual market only
17 through one or more associations described in clause
18 (ii), the membership of the individual in the associa-
19 tion (on the basis of which the coverage is provided)
20 ceases but only if such coverage is terminated under
21 this subparagraph uniformly without regard to any
22 health status-related factor of covered individuals
23 and only if the individual is entitled, upon applica-
24 tion and without furnishing evidence of insurability,
25 to health insurance conversion coverage that meets

and is subject to all the rules and regulations of the State in which application is made.

"(ii) An association described in this clause is an organization that meets the requirements for a bona fide organization described in subparagraphs (A), (B), (C), (E) and (F) of section 2791(d)(3) and, except in the case of an association that enrolls individual members who each pay their own individual membership dues, which provides that all members and dependents of members are eligible for coverage offered through the association regardless of any health status-related factor.".

TITLE III—GREATER ACCESS AND CHOICE THROUGH HEALTHMARTS

SEC. 301. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XXVIII—HEALTHMARTS

"SEC. 2801. DEFINITION OF HEALTHMART.

"(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

1 "(1) ORGANIZATION.—The HealthMart is a
2 nonprofit organization operated under the direction
3 of a board of directors which is composed of rep-
4 resentatives of not fewer than 2 and in equal num-
5 bers from each of the following:

6 "(A) Small employers.

7 "(B) Employees of small employers.

8 "(C) Health care providers, which may be
9 physicians, other health care professionals,
10 health care facilities, or any combination there-
11 of.

12 "(D) Entities, such as insurance compa-
13 nies, health maintenance organizations, and li-
14 censed provider-sponsored organizations, that
15 underwrite or administer health benefits cov-
16 erage.

17 "(2) OFFERING HEALTH BENEFITS COV-
18 ERAGE.—

19 "(A) IN GENERAL.—The HealthMart, in
20 conjunction with those health insurance issuers
21 that offer health benefits coverage through the
22 HealthMart, makes available health benefits
23 coverage in the manner described in subsection
24 (b) to all small employers and eligible employees
25 in the manner described in subsection (c)(2) at

1 rates (including employer's and employee's
2 share) that are established by the health insur-
3 ance issuer on a policy or product specific basis
4 and that may vary only as permissible under
5 State law. A HealthMart is deemed to be a
6 group health plan for purposes of applying sec-
7 tion 702 of the Employee Retirement Income
8 Security Act of 1974, section 2702 of this Act,
9 and section 9802(b) of the Internal Revenue
10 Code of 1986 (which limit variation among
11 similarly situated individuals of required pre-
12 miums for health benefits coverage on the basis
13 of health status-related factors).

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

16 ''(i) IN GENERAL.—Subject to clause
17 (ii), the HealthMart may not offer health
18 benefits coverage to an eligible employee in
19 a geographic area (as specified under para-
20 graph (3)(A)) unless the same coverage is
21 offered to all such employees in the same
22 geographic area. Section 2711(a)(1)(B) of
23 this Act limits denial of enrollment of cer-
24 tain eligible individuals under health bene-
25 fits coverage in the small group market.

1 "(ii) CONSTRUCTION.—Nothing in
2 this title shall be construed as requiring or
3 permitting a health insurance issuer to
4 provide coverage outside the service area of
5 the issuer, as approved under State law.
6 "(C) NO FINANCIAL UNDERWRITING.—The
7 HealthMart provides health benefits coverage
8 only through contracts with health insurance
9 issuers and does not assume insurance risk with
10 respect to such coverage.
11 (D) MINIMUM COVERAGE.—By the end of
12 the first year of its operation and thereafter,
13 the HealthMart maintains not fewer than 10
14 purchasers and 100 members.
15 "(3) GEOGRAPHIC AREAS.—
16 "(A) SPECIFICATION OF GEOGRAPHIC
17 AREAS.—The HealthMart shall specify the geo-
18 graphic area (or areas) in which it makes avail-
19 able health benefits coverage offered by health
20 insurance issuers to small employers. Such an
21 area shall encompass at least one entire county
22 or equivalent area.
23 "(B) MULTISTATE AREAS.—In the case of
24 a HealthMart that serves more than one State,
25 such geographic areas may be areas that in-

1 clude portions of two or more contiguous
2 States.
3 "(C) MULTIPLE HEALTHMARTS PER-
4 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-
5 ing in this title shall be construed as preventing
6 the establishment and operation of more than
7 one HealthMart in a geographic area or as lim-
8 iting the number of HealthMarts that may op-
9 erate in any area.
10 "(4) PROVISION OF ADMINISTRATIVE SERVICES
11 TO PURCHASERS.—
12 "(A) IN GENERAL.—The HealthMart pro-
13 vides administrative services for purchasers.
14 Such services may include accounting, billing,
15 enrollment information, and employee coverage
16 status reports.
17 "(B) CONSTRUCTION.—Nothing in this
18 subsection shall be construed as preventing a
19 HealthMart from serving as an administrative
20 service organization to any entity.
21 "(5) DISSEMINATION OF INFORMATION.—The
22 HealthMart collects and disseminates (or arranges
23 for the collection and dissemination of) consumer-
24 oriented information on the scope, cost, and enrollee
25 satisfaction of all coverage options offered through

the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

"(6) FILING INFORMATION.—The HealthMart—

"(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

"(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

"(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

1 "(1) COMPLIANCE WITH CONSUMER PROTEC-
2 TION REQUIREMENTS.—Any health benefits coverage
3 offered through a HealthMart shall—
4 "(A) be underwritten by a health insurance
5 issuer that—
6 "(i) is licensed (or otherwise regu-
7 lated) under State law (or is a community
8 health organization that is offering health
9 insurance coverage pursuant to section
10 330B(a));
11 "(ii) meets all applicable State stand-
12 ards relating to consumer protection, sub-
13 ject to section 2802(b); and
14 "(iii) offers the coverage under a con-
15 tract with the HealthMart;
16 "(B) subject to paragraph (2), be approved
17 or otherwise permitted to be offered under
18 State law; and
19 "(C) provide full portability of creditable
20 coverage for individuals who remain members of
21 the same HealthMart notwithstanding that they
22 change the employer through which they are
23 members in accordance with the provisions of
24 the parts 6 and 7 of subtitle B of title I of the
25 Employee Retirement Income Security Act of

1 1974 and titles XXII and XXVII of this Act,
2 so long as both employers are purchasers in the
3 HealthMart.

4 "(2) ALTERNATIVE PROCESS FOR APPROVAL OF
5 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMI-
6 NATION OR DELAY.—

7 "(A) IN GENERAL.—The requirement of
8 paragraph (1)(B) shall not apply to a policy or
9 product of health benefits coverage offered in a
10 State if the health insurance issuer seeking to
11 offer such policy or product files an application
12 to waive such requirement with the applicable
13 Federal authority, and the authority deter-
14 mines, based on the application and other evi-
15 dence presented to the authority, that—

16 "(i) either (or both) of the grounds
17 described in subparagraph (B) for approval
18 of the application has been met; and

19 "(ii) the coverage meets the applicable
20 State standards (other than those that
21 have been preempted under section 2802).

22 "(B) GROUNDS.—The grounds described
23 in this subparagraph with respect to a policy or
24 product of health benefits coverage are as fol-
25 lows:

1 "(i) FAILURE TO ACT ON POLICY,
2 PRODUCT, OR RATE APPLICATION ON A
3 TIMELY BASIS.—The State has failed to
4 complete action on the policy or product
5 (or rates for the policy or product) within
6 90 days of the date of the State's receipt
7 of a substantially complete application. No
8 period before the date of the enactment of
9 this section shall be included in deter-
10 mining such 90-day period.
11 "(ii) DENIAL OF APPLICATION BASED
12 ON DISCRIMINATORY TREATMENT.—The
13 State has denied such an application
14 and—
15 "(I) the standards or review
16 process imposed by the State as a
17 condition of approval of the policy or
18 product imposes either any material
19 requirements, procedures, or stand-
20 ards to such policy or product that
21 are not generally applicable to other
22 policies and products offered or any
23 requirements that are preempted
24 under section 2802; or

1 "(II) the State requires the
2 issuer, as a condition of approval of
3 the policy or product, to offer any pol-
4 icy or product other than such policy
5 or product.

6 "(C) ENFORCEMENT.—In the case of a
7 waiver granted under subparagraph (A) to an
8 issuer with respect to a State, the Secretary
9 may enter into an agreement with the State
10 under which the State agrees to provide for
11 monitoring and enforcement activities with re-
12 spect to compliance of such an issuer and its
13 health insurance coverage with the applicable
14 State standards described in subparagraph
15 (A)(ii). Such monitoring and enforcement shall
16 be conducted by the State in the same manner
17 as the State enforces such standards with re-
18 spect to other health insurance issuers and
19 plans, without discrimination based on the type
20 of issuer to which the standards apply. Such an
21 agreement shall specify or establish mechanisms
22 by which compliance activities are undertaken,
23 while not lengthening the time required to re-
24 view and process applications for waivers under
25 subparagraph (A).

1 ‘‘(3) EXAMPLES OF TYPES OF COVERAGE.—The
2 health benefits coverage made available through a
3 HealthMart may include, but is not limited to, any
4 of the following if it meets the other applicable re-
5 quirements of this title:
6 ‘‘(A) Coverage through a health mainte-
7 nance organization.
8 ‘‘(B) Coverage in connection with a pre-
9 ferred provider organization.
10 ‘‘(C) Coverage in connection with a li-
11 censed provider-sponsored organization.
12 ‘‘(D) Indemnity coverage through an insur-
13 ance company.
14 ‘‘(E) Coverage offered in connection with a
15 contribution into a medical savings account or
16 flexible spending account.
17 ‘‘(F) Coverage that includes a point-of-
18 service option.
19 ‘‘(G) Coverage offered by a community
20 health organization (as defined in section
21 330B(e)).
22 ‘‘(H) Any combination of such types of
23 coverage.
24 ‘‘(4) WELLNESS BONUSES FOR HEALTH PRO-
25 MOTION.—Nothing in this title shall be construed as

1 precluding a health insurance issuer offering health
2 benefits coverage through a HealthMart from estab-
3 lishing premium discounts or rebates for members or
4 from modifying otherwise applicable copayments or
5 deductibles in return for adherence to programs of
6 health promotion and disease prevention so long as
7 such programs are agreed to in advance by the
8 HealthMart and comply with all other provisions of
9 this title and do not discriminate among similarly
10 situated members.

11 ''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE
12 ISSUERS.—

13 ''(1) PURCHASERS.—

14 ''(A) IN GENERAL.—Subject to the provi-
15 sions of this title, a HealthMart shall permit
16 any small employer to contract with the
17 HealthMart for the purchase of health benefits
18 coverage for its employees and dependents of
19 those employees and may not vary conditions of
20 eligibility (including premium rates and mem-
21 bership fees) of a small employer to be a pur-
22 chaser.

23 ''(B) ROLE OF ASSOCIATIONS, BROKERS,
24 AND LICENSED HEALTH INSURANCE AGENTS.—
25 Nothing in this section shall be construed as

1 preventing an association, broker, licensed
2 health insurance agent, or other entity from as-
3 sisting or representing a HealthMart or small
4 employers from entering into appropriate ar-
5 rangements to carry out this title.

6 ‘‘(C) PERIOD OF CONTRACT.—The
7 HealthMart may not require a contract under
8 subparagraph (A) between a HealthMart and a
9 purchaser to be effective for a period of longer
10 than 12 months. The previous sentence shall
11 not be construed as preventing such a contract
12 from being extended for additional 12-month
13 periods or preventing the purchaser from volun-
14 tarily electing a contract period of longer than
15 12 months.

16 ‘‘(D) EXCLUSIVE NATURE OF CON-
17 TRACT.—Such a contract shall provide that the
18 purchaser agrees not to obtain or sponsor
19 health benefits coverage, on behalf of any eligi-
20 ble employees (and their dependents), other
21 than through the HealthMart. The previous
22 sentence shall not apply to an eligible individual
23 who resides in an area for which no coverage is
24 offered by any health insurance issuer through
25 the HealthMart.

1 "(2) MEMBERS.—

2 "(A) IN GENERAL.—Under rules estab-
3 lished to carry out this title, with respect to a
4 small employer that has a purchaser contract
5 with a HealthMart, individuals who are employ-
6 ees of the employer may enroll for health bene-
7 fits coverage (including coverage for dependents
8 of such enrolling employees) offered by a health
9 insurance issuer through the HealthMart.

10 "(B) NONDISCRIMINATION IN ENROLL-
11 MENT.—A HealthMart may not deny enroll-
12 ment as a member to an individual who is an
13 employee (or dependent of such an employee)
14 eligible to be so enrolled based on health status-
15 related factors, except as may be permitted con-
16 sistent with section 2742(b).

17 "(C) ANNUAL OPEN ENROLLMENT PE-
18 RIOD.—In the case of members enrolled in
19 health benefits coverage offered by a health in-
20 surance issuer through a HealthMart, subject
21 to subparagraph (D), the HealthMart shall pro-
22 vide for an annual open enrollment period of 30
23 days during which such members may change
24 the coverage option in which the members are
25 enrolled.

1 “(D) RULES OF ELIGIBILITY.—Nothing in
2 this paragraph shall preclude a HealthMart
3 from establishing rules of employee eligibility
4 for enrollment and reenrollment of members
5 during the annual open enrollment period under
6 subparagraph (C). Such rules shall be applied
7 consistently to all purchasers and members
8 within the HealthMart and shall not be based
9 in any manner on health status-related factors
10 and may not conflict with sections 2701 and
11 2702 of this Act.

12 “(3) HEALTH INSURANCE ISSUERS.—

13 “(A) PREMIUM COLLECTION.—The con-
14 tract between a HealthMart and a health insur-
15 ance issuer shall provide, with respect to a
16 member enrolled with health benefits coverage
17 offered by the issuer through the HealthMart,
18 for the payment of the premiums collected by
19 the HealthMart (or the issuer) for such cov-
20 erage (less a pre-determined administrative
21 charge negotiated by the HealthMart and the
22 issuer) to the issuer.

23 “(B) SCOPE OF SERVICE AREA.—Nothing
24 in this title shall be construed as requiring the
25 service area of a health insurance issuer with

1 respect to health insurance coverage to cover
2 the entire geographic area served by a
3 HealthMart.

4 "(C) AVAILABILITY OF COVERAGE OP-
5 TIONS.—A HealthMart shall enter into con-
6 tracts with one or more health insurance issuers
7 in a manner that assures that at least 2 health
8 insurance coverage options are made available
9 in the geographic area specified under sub-
10 section (a)(3)(A).

11 "(d) PREVENTION OF CONFLICTS OF INTEREST.—

12 "(1) FOR BOARDS OF DIRECTORS.—A member
13 of a board of directors of a HealthMart may not
14 serve as an employee or paid consultant to the
15 HealthMart, but may receive reasonable reimburse-
16 ment for travel expenses for purposes of attending
17 meetings of the board or committees thereof.

18 "(2) FOR BOARDS OF DIRECTORS OR EMPLOY-
19 EES.—An individual is not eligible to serve in a paid
20 or unpaid capacity on the board of directors of a
21 HealthMart or as an employee of the HealthMart, if
22 the individual is employed by, represents in any ca-
23 pacity, owns, or controls any ownership interest in
24 a organization from whom the HealthMart receives
25 contributions, grants, or other funds not connected

1 with a contract for coverage through the
2 HealthMart.
3 ‘‘(3) EMPLOYMENT AND EMPLOYEE REP-
4 RESENTATIVES.—
5 ‘‘(A) IN GENERAL.—An individual who is
6 serving on a board of directors of a HealthMart
7 as a representative described in subparagraph
8 (A) or (B) of section 2801(a)(1) shall not be
9 employed by or affiliated with a health insur-
10 ance issuer or be licensed as or employed by or
11 affiliated with a health care provider.
12 ‘‘(B) CONSTRUCTION.—For purposes of
13 subparagraph (A), the term ‘‘affiliated’’ does
14 not include membership in a health benefits
15 plan or the obtaining of health benefits cov-
16 erage offered by a health insurance issuer.
17 ‘‘(e) CONSTRUCTION.—
18 ‘‘(1) NETWORK OF AFFILIATED
19 HEALTHMARTS.—Nothing in this section shall be
20 construed as preventing one or more HealthMarts
21 serving different areas (whether or not contiguous)
22 from providing for some or all of the following
23 (through a single administrative organization or oth-
24 erwise):

1 "(A) Coordinating the offering of the same
2 or similar health benefits coverage in different
3 areas served by the different HealthMarts.
4 "(B) Providing for crediting of deductibles
5 and other cost-sharing for individuals who are
6 provided health benefits coverage through the
7 HealthMarts (or affiliated HealthMarts)
8 after—
9 "(i) a change of employers through
10 which the coverage is provided; or
11 "(ii) a change in place of employment
12 to an area not served by the previous
13 HealthMart.
14 "(2) PERMITTING HEALTHMARTS TO ADJUST
15 DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-
16 ATIVE RISK OF ENROLLEES.—Nothing in this sec-
17 tion shall be construed as precluding a HealthMart
18 from providing for adjustments in amounts distrib-
19 uted among the health insurance issuers offering
20 health benefits coverage through the HealthMart
21 based on factors such as the relative health care risk
22 of members enrolled under the coverage offered by
23 the different issuers.
24 "(3) APPLICATION OF UNIFORM MINIMUM PAR-
25 TICIPATION AND CONTRIBUTION RULES.—Nothing

1 in this section shall be construed as precluding a
2 HealthMart from establishing minimum participa-
3 tion and contribution rules (described in section
4 2711(e)(1)) for small employers that apply to be-
5 come purchasers in the HealthMart, so long as such
6 rules are applied uniformly for all health insurance
7 issuers.

8 **"SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
9 **MENTS.**

10 "(a) AUTHORITY OF STATES.—Nothing in this sec-
11 tion shall be construed as preempting State laws relating
12 to the following:

13 "(1) The regulation of underwriters of health
14 coverage, including licensure and solvency require-
15 ments.

16 "(2) The application of premium taxes and re-
17 quired payments for guaranty funds or for contribu-
18 tions to high-risk pools.

19 "(3) The application of fair marketing require-
20 ments and other consumer protections (other than
21 those specifically relating to an item described in
22 subsection (b)).

23 "(4) The application of requirements relating to
24 the adjustment of rates for health insurance cov-
25 erage.

1 “(b) TREATMENT OF BENEFIT AND GROUPING RE-
2 QUIREMENTS.—State laws insofar as they relate to any
3 of the following are superseded and shall not apply to
4 health benefits coverage made available through a
5 HealthMart:

6 “(1) Benefit requirements for health benefits
7 coverage offered through a HealthMart, including
8 (but not limited to) requirements relating to cov-
9 erage of specific providers, specific services or condi-
10 tions, or the amount, duration, or scope of benefits,
11 but not including requirements to the extent re-
12 quired to implement title XXVII or other Federal
13 law and to the extent the requirement prohibits an
14 exclusion of a specific disease from such coverage.

15 “(2) Requirements (commonly referred to as
16 fictitious group laws) relating to grouping and simi-
17 lar requirements for such coverage to the extent
18 such requirements impede the establishment and op-
19 eration of HealthMarts pursuant to this title.

20 “(3) Any other requirements (including limita-
21 tions on compensation arrangements) that, directly
22 or indirectly, preclude (or have the effect of pre-
23 cluding) the offering of such coverage through a
24 HealthMart, if the HealthMart meets the require-
25 ments of this title.

1 Any State law or regulation relating to the composition
2 or organization of a HealthMart is preempted to the ex-
3 tent the law or regulation is inconsistent with the provi-
4 sions of this title.

5 "(c) APPLICATION OF ERISA FIDUCIARY AND DIS-
6 CLOSURE REQUIREMENTS.—The board of directors of a
7 HealthMart is deemed to be a plan administrator of an
8 employee welfare benefit plan which is a group health plan
9 for purposes of applying parts 1 and 4 of subtitle B of
10 title I of the Employee Retirement Income Security Act
11 of 1974 and those provisions of part 5 of such subtitle
12 which are applicable to enforcement of such parts 1 and
13 4, and the HealthMart shall be treated as such a plan
14 and the enrollees shall be treated as participants and bene-
15 ficiaries for purposes of applying such provisions pursuant
16 to this subsection.

17 "(d) APPLICATION OF ERISA RENEWABILITY PRO-
18 TECTION.—A HealthMart is deemed to be a group health
19 plan that is a multiple employer welfare arrangement for
20 purposes of applying section 703 of the Employee Retire-
21 ment Income Security Act of 1974.

22 "(e) APPLICATION OF RULES FOR NETWORK PLANS
23 AND FINANCIAL CAPACITY.—The provisions of sub-
24 sections (c) and (d) of section 2711 apply to health bene-

1 fits coverage offered by a health insurance issuer through
2 a HealthMart.

3 “(f) CONSTRUCTION RELATING TO OFFERING RE-
4 QUIREMENT.—Nothing in section 2711(a) of this Act or
5 703 of the Employee Retirement Income Security Act of
6 1974 shall be construed as permitting the offering outside
7 the HealthMart of health benefits coverage that is only
8 made available through a HealthMart under this section
9 because of the application of subsection (b).

10 “(g) APPLICATION TO GUARANTEED RENEWABILITY
11 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN
12 ISSUER.—For purposes of applying section 2712 in the
13 case of health insurance coverage offered by a health in-
14 surance issuer through a HealthMart, if the contract be-
15 tween the HealthMart and the issuer is terminated and
16 the HealthMart continues to make available any health in-
17 surance coverage after the date of such termination, the
18 following rules apply:

19 “(1) RENEWABILITY.—The HealthMart shall
20 fulfill the obligation under such section of the issuer
21 renewing and continuing in force coverage by offer-
22 ing purchasers (and members and their dependents)
23 all available health benefits coverage that would oth-
24 erwise be available to similarly-situated purchasers
25 and members from the remaining participating

1 health insurance issuers in the same manner as
2 would be required of issuers under section 2712(c).
3 "(2) APPLICATION OF ASSOCIATION RULES.—
4 The HealthMart shall be considered an association
5 for purposes of applying section 2712(e).
6 "(h) CONSTRUCTION IN RELATION TO CERTAIN
7 OTHER LAWS.—Nothing in this title shall be construed
8 as modifying or affecting the applicability to HealthMarts
9 or health benefits coverage offered by a health insurance
10 issuer through a HealthMart of parts 6 and 7 of subtitle
11 B of title I of the Employee Retirement Income Security
12 Act of 1974 or titles XXII and XXVII of this Act.
13 **"SEC. 2803. ADMINISTRATION.**
14 "(a) IN GENERAL.—The applicable Federal authority
15 shall administer this title through the division established
16 under subsection (b) and is authorized to issue such regu-
17 lations as may be required to carry out this title. Such
18 regulations shall be subject to Congressional review under
19 the provisions of chapter 8 of title 5, United States Code.
20 The applicable Federal authority shall incorporate the
21 process of 'deemed file and use' with respect to the infor-
22 mation filed under section 2801(a)(6)(A) and shall deter-
23 mine whether information filed by a HealthMart dem-
24 onstrates compliance with the applicable requirements of
25 this title. Such authority shall exercise its authority under

1 this title in a manner that fosters and promotes the devel-
2 opment of HealthMarts in order to improve access to
3 health care coverage and services.

4 ‘‘(b) ADMINISTRATION THROUGH HEALTH CARE
5 MARKETPLACE DIVISION.—

6 ‘‘(1) IN GENERAL.—The applicable Federal au-
7 thority shall carry out its duties under this title
8 through a separate Health Care Marketplace Divi-
9 sion, the sole duty of which (including the staff of
10 which) shall be to administer this title.

11 ‘‘(2) ADDITIONAL DUTIES.—In addition to
12 other responsibilities provided under this title, such
13 Division is responsible for—

14 ‘‘(A) oversight of the operations of
15 HealthMarts under this title; and

16 ‘‘(B) the periodic submittal to Congress of
17 reports on the performance of HealthMarts
18 under this title under subsection (c).

19 ‘‘(c) PERIODIC REPORTS.—The applicable Federal
20 authority shall submit to Congress a report every 30
21 months, during the 10-year period beginning on the effec-
22 tive date of the rules promulgated by the applicable Fed-
23 eral authority to carry out this title, on the effectiveness
24 of this title in promoting coverage of uninsured individ-
25 uals. Such authority may provide for the production of

such reports through one or more contracts with appropriate private entities.

"SEC. 2804. DEFINITIONS.

"For purposes of this title:

"(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services.

"(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

"(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

"(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the

1 term group health insurance coverage in section
2 2791(b)(4).
3 "(5) HEALTH INSURANCE ISSUER.—The term
4 'health insurance issuer' has the meaning given such
5 term in section 2791(b)(2) and includes a commu-
6 nity health organization that is offering coverage
7 pursuant to section 330B(a).
8 "(6) HEALTH STATUS-RELATED FACTOR.—The
9 term 'health status-related factor' has the meaning
10 given such term in section 2791(d)(9).
11 "(7) HEALTHMART.—The term 'HealthMart' is
12 defined in section 2801(a).
13 "(8) MEMBER.—The term 'member' means,
14 with respect to a HealthMart, an individual enrolled
15 for health benefits coverage through the HealthMart
16 under section 2801(c)(2).
17 "(9) PURCHASER.—The term 'purchaser'
18 means, with respect to a HealthMart, a small em-
19 ployer that has contracted under section
20 2801(c)(1)(A) with the HealthMart for the purchase
21 of health benefits coverage.
22 "(10) SMALL EMPLOYER.—The term 'small em-
23 ployer' has the meaning given such term for pur-
24 poses of title XXVII.".

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect on January 1, 2000. The
3 Secretary of Health and Human Services shall first issue
4 all regulations necessary to carry out such amendment be-
5 fore such date.

6 TITLE IV—COMMUNITY HEALTH
7 ORGANIZATIONS

8 **SEC. 401. PROMOTION OF PROVISION OF INSURANCE BY**
9 **COMMUNITY HEALTH ORGANIZATIONS.**

10 (a) WAIVER OF STATE LICENSURE REQUIREMENT
11 FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN
12 CASES.—Subpart I of part D of title III of the Public
13 Health Service Act is amended by adding at the end the
14 following new section:

15 ''WAIVER OF STATE LICENSURE REQUIREMENT FOR
16 COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

17 ''SEC. 330D. (a) WAIVER AUTHORIZED.—
18 ''(1) IN GENERAL.—A community health orga-
19 nization may offer health insurance coverage in a
20 State notwithstanding that it is not licensed in such
21 a State to offer such coverage if—
22 ''(A) the organization files an application
23 for waiver of the licensure requirement with the
24 Secretary of Health and Human Services (in
25 this section referred to as the 'Secretary') by
26 not later than November 1, 2005; and

1 "(B) the Secretary determines, based on
2 the application and other evidence presented to
3 the Secretary, that any of the grounds for ap-
4 proval of the application described in subpara-
5 graph (A), (B), or (C) of paragraph (2) has
6 been met.

7 "(2) GROUNDS FOR APPROVAL OF WAIVER.—

8 "(A) FAILURE TO ACT ON LICENSURE AP-
9 PLICATION ON A TIMELY BASIS.—The ground
10 for approval of such a waiver application de-
11 scribed in this subparagraph is that the State
12 has failed to complete action on a licensing ap-
13 plication of the organization within 90 days of
14 the date of the State's receipt of a substantially
15 complete application. No period before the date
16 of the enactment of this section shall be in-
17 cluded in determining such 90-day period.

18 "(B) DENIAL OF APPLICATION BASED ON
19 DISCRIMINATORY TREATMENT.—The ground for
20 approval of such a waiver application described
21 in this subparagraph is that the State has de-
22 nied such a licensing application and the stand-
23 ards or review process imposed by the State as
24 a condition of approval of the license or as the
25 basis for such denial by the State imposes any

material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

"(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

1 "(3) TREATMENT OF WAIVER.—In the case of
2 a waiver granted under this subsection for a commu-
3 nity health organization with respect to a State—
4 "(A) LIMITATION TO STATE.—The waiver
5 shall be effective only with respect to that State
6 and does not apply to any other State.
7 "(B) LIMITATION TO 36-MONTH PERIOD.—
8 The waiver shall be effective only for a 36-
9 month period but may be renewed for up to 36
10 additional months if the Secretary determines
11 that such an extension is appropriate.
12 "(C) CONDITIONED ON COMPLIANCE WITH
13 CONSUMER PROTECTION AND QUALITY STAND-
14 ARDS.—The continuation of the waiver is condi-
15 tioned upon the organization's compliance with
16 the requirements described in paragraph (5).
17 "(D) PREEMPTION OF STATE LAW.—Any
18 provisions of law of that State which relate to
19 the licensing of the organization and which pro-
20 hibit the organization from providing health in-
21 surance coverage shall be superseded.
22 "(4) PROMPT ACTION ON APPLICATION.—The
23 Secretary shall grant or deny such a waiver applica-
24 tion within 60 days after the date the Secretary de-
25 termines that a substantially complete waiver appli-

1 cation has been filed. Nothing in this section shall
2 be construed as preventing an organization which
3 has had such a waiver application denied from sub-
4 mitting a subsequent waiver application.

5 ''(5) APPLICATION AND ENFORCEMENT OF
6 STATE CONSUMER PROTECTION AND QUALITY
7 STANDARDS.—A waiver granted under this sub-
8 section to an organization with respect to licensing
9 under State law is conditioned upon the organiza-
10 tion's compliance with all consumer protection and
11 quality standards insofar as such standards—

12 ''(A) would apply in the State to the com-
13 munity health organization if it were licensed as
14 an entity offering health insurance coverage
15 under State law; and

16 ''(B) are generally applicable to other risk-
17 bearing managed care organizations and plans
18 in the State.

19 ''(6) REPORT.—By not later than December 31,
20 2004, the Secretary shall submit to the Committee
21 on Commerce of the House of Representatives and
22 the Committee on Labor and Human Resources of
23 the Senate a report regarding whether the waiver
24 process under this subsection should be continued
25 after December 31, 2005.

1 "(b) ASSUMPTION OF FULL FINANCIAL RISK.—To
2 qualify for a waiver under subsection (a), the community
3 health organization shall assume full financial risk on a
4 prospective basis for the provision of covered health care
5 services, except that the organization—

6 "(1) may obtain insurance or make other ar-
7 rangements for the cost of providing to any enrolled
8 member such services the aggregate value of which
9 exceeds such aggregate level as the Secretary speci-
10 fies from time to time;

11 "(2) may obtain insurance or make other ar-
12 rangements for the cost of such services provided to
13 its enrolled members other than through the organi-
14 zation because medical necessity required their pro-
15 vision before they could be secured through the orga-
16 nization;

17 "(3) may obtain insurance or make other ar-
18 rangements for not more than 90 percent of the
19 amount by which its costs for any of its fiscal years
20 exceed 105 percent of its income for such fiscal year;
21 and

22 "(4) may make arrangements with physicians
23 or other health care professionals, health care insti-
24 tutions, or any combination of such individuals or
25 institutions to assume all or part of the financial

1 risk on a prospective basis for the provision of
2 health services by the physicians or other health pro-
3 fessionals or through the institutions.

4 "(c) CERTIFICATION OF PROVISION AGAINST RISK
5 OF INSOLVENCY FOR UNLICENSED CHOS.—

6 "(1) IN GENERAL.—Each community health or-
7 ganization that is not licensed by a State and for
8 which a waiver application has been approved under
9 subsection (a)(1), shall meet standards established
10 by the Secretary under subsection (d) relating to the
11 financial solvency and capital adequacy of the orga-
12 nization.

13 "(2) CERTIFICATION PROCESS FOR SOLVENCY
14 STANDARDS FOR CHOS.—The Secretary shall estab-
15 lish a process for the receipt and approval of appli-
16 cations of a community health organization de-
17 scribed in paragraph (1) for certification (and peri-
18 odic recertification) of the organization as meeting
19 such solvency standards. Under such process, the
20 Secretary shall act upon such a certification applica-
21 tion not later than 60 days after the date the appli-
22 cation has been received.

23 "(d) ESTABLISHMENT OF SOLVENCY STANDARDS
24 FOR COMMUNITY HEALTH ORGANIZATIONS.—

1 "(1) IN GENERAL.—The Secretary shall estab-
2 lish, on an expedited basis and by rule pursuant to
3 section 553 of title 5, United States Code and
4 through the Health Resources and Services Adminis-
5 tration, standards described in subsection (c)(1) (re-
6 lating to financial solvency and capital adequacy)
7 that entities must meet to obtain a waiver under
8 subsection (a)(2)(C). In establishing such standards,
9 the Secretary shall consult with interested organiza-
10 tions, including the National Association of Insur-
11 ance Commissioners, the Academy of Actuaries, and
12 organizations representing Federally qualified health
13 centers.

14 "(2) FACTORS TO CONSIDER FOR SOLVENCY
15 STANDARDS.—In establishing solvency standards for
16 community health organizations under paragraph
17 (1), the Secretary shall take into account—

18 "(A) the delivery system assets of such an
19 organization and ability of such an organization
20 to provide services to enrollees;

21 "(B) alternative means of protecting
22 against insolvency, including reinsurance, unre-
23 stricted surplus, letters of credit, guarantees,
24 organizational insurance coverage, partnerships
25 with other licensed entities, and valuation at-

1 tributable to the ability of such an organization
2 to meet its service obligations through direct
3 delivery of care; and

4 ''(C) any standards developed by the Na-
5 tional Association of Insurance Commissioners
6 specifically for risk-based health care delivery
7 organizations.

8 ''(3) ENROLLEE PROTECTION AGAINST INSOL-
9 VENCY.—Such standards shall include provisions to
10 prevent enrollees from being held liable to any per-
11 son or entity for the organization's debts in the
12 event of the organization's insolvency.

13 ''(4) DEADLINE.—Such standards shall be pro-
14 mulgated in a manner so they are first effective by
15 not later than April 1, 2000.

16 ''(e) DEFINITIONS.—In this section:

17 ''(1) COMMUNITY HEALTH ORGANIZATION.—
18 The term 'community health organization' means an
19 organization that is a Federally-qualified health cen-
20 ter or is controlled by one or more Federally-quali-
21 fied health centers.

22 ''(2) FEDERALLY-QUALIFIED HEALTH CEN-
23 TER.—The term 'Federally-qualified health center'
24 has the meaning given such term in section
25 1905(l)(2)(B) of the Social Security Act.

1 "(3) HEALTH INSURANCE COVERAGE.—The
2 term 'health insurance coverage' has the meaning
3 given such term in section 2791(b)(1).
4 "(4) CONTROL.—The term 'control' means the
5 possession, whether direct or indirect, of the power
6 to direct or cause the direction of the management
7 and policies of the organization through member-
8 ship, board representation, or an ownership interest
9 equal to or greater than 50.1 percent.".

○