I

107TH CONGRESS
1ST SESSION

H. R. 1331

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to establish State health insurance safety-net programs.

IN THE HOUSE OF REPRESENTATIVES

APRIL 3, 2001

Mr. ARMEY (for himself, Mr. LIPINSKI, Mr. CANNON, Mr. FORD, Mr. BONILLA, Mr. BLAGOJEVICH, Mr. BALLENGER, Mrs. BONO, Mr. BUYER, Mr. CANTOR, Mrs. JO ANN DAVIS of Virginia, Mr. TOM DAVIS of Virginia, Mr. FOSSELLA, Mr. GILLMOR, Ms. HART, Mr. HOSTETTLER, Mr. ISAKSON, Mr. KOLBE, Mr. MCHUGH, Ms. PRYCE of Ohio, Mr. REHBERG, Mr. ROGERS of Michigan, Mr. SENSENBRENNER, Mr. SMITH of New Jersey, and Mr. TANCREDO) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to establish State health insurance safety-net programs.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Fair Care for the Uninsured Act of 2001''.

TITLE I—REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE

SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

''SEC. 35. HEALTH INSURANCE COSTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for the taxpayer, his spouse, and dependents.

''(b) LIMITATIONS.—

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

any amount for coverage under qualified health insurance.

''(2) MONTHLY LIMITATION.—

''(A) IN GENERAL.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of—

''(i) $1,000 if such individual is the taxpayer,

''(ii) $1,000 if—

''(I) such individual is the spouse of the taxpayer,

''(II) the taxpayer and such spouse are married as of the first day of such month, and

''(III) the taxpayer files a joint return for the taxable year, and

''(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

''(B) LIMITATION TO 2 DEPENDENTS.—Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (A)(iii).

''(C) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of an individual—

''(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

''(ii) who does not live apart from such individual's spouse at all times during the taxable year,

the limitation imposed by subparagraph (B) shall be divided equally between the individual and the individual's spouse unless they agree on a different division.

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

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

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

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

"(B) EMPLOYER-SUBSIDIZED COVERAGE.—

"(i) IN GENERAL.—Such term shall not include any month for which such individual is eligible to participate in any subsidized health plan (within the meaning of section 162(l)(2)) maintained by any employer of the taxpayer or of the spouse of the taxpayer.

"(ii) PREMIUMS TO NONSUBSIDIZED PLANS.—If an employer of the taxpayer or the spouse of the taxpayer maintains a health plan which is not a subsidized health plan (as so defined) and which constitutes qualified health insurance, employee contributions to the plan shall be treated as amounts paid for qualified health insurance.

"(C) CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT BENEFICIARIES.—Such term shall not include any month during a taxable year if any amount is not includible in the gross income of the taxpayer for such year under section 106 with respect to—

"(i) a benefit chosen under a cafeteria plan (as defined in section 125(d)), or

"(ii) a benefit provided under a flexible spending or similar arrangement.

"(D) MEDICARE AND MEDICAID.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual—

"(i) is entitled to any benefits under title XVIII of the Social Security Act, or

"(ii) is a participant in the program under title XIX or XXI of such Act.

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

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

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

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

"(iv) any medical care program under the Indian Health Care Improvement Act.

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

''(G) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(4) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care as defined in section 213(d) without regard to—

"(A) paragraph (1)(C) thereof, and

"(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

"(2) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

"(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—

"(1) IN GENERAL.—If a deduction would (but for paragraph (2)) be allowed under section 220 to the taxpayer for a payment for the taxable year to the medical savings account of an individual, subsection (a) shall be applied by treating such payment as a payment for qualified health insurance for such individual.

"(2) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under section 220 for that portion of the payments otherwise allowable as a deduction under section 220 for the taxable year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

"(e) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(3) INFLATION ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2002, each dollar amount contained in subsection (b)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50 ($25 in the case of the dollar amount in subsection (b)(2)(A)(iii)).''

(b) MAINTENANCE OF EFFORT REQUIREMENT.—Section 162 of such Code (relating to trade or business expenses) is amended by redesignating subsection (p) as subsection (q) and by inserting after subsection (o) the following new subsection:

''(p) GROUP HEALTH PLAN MAINTENANCE OF EFFORT.—No deduction shall be allowed under this chapter to an employer for any amount paid or incurred in connection with a group health plan (as defined in subsection (n)(3)) for any taxable year in which occurs the date of introduction of the Fair Care for the Uninsured Act of 2001 unless such plan remains in effect for at least 60 months after the date of the enactment of such Act.''.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code (relating to information concerning transactions with other persons) is amended by inserting after section 6050S the following new section:

"SEC. 6050T. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

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

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

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

"(2) contains—

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

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

"(C) such other information as the Secretary may reasonably prescribe.

''(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 35(c)) other than—

''(1) insurance under a subsidized group health plan maintained by an employer, or

''(2) to the extent provided in regulations prescribed by the Secretary, any other insurance covering an individual if no credit is allowable under section 35 with respect to such coverage.

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

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

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

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

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

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

(2) ASSESSABLE PENALTIES.—

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

''(xi) section 6050T (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of the next to last subparagraph, by striking the period at the end of the last subpara-

graph and inserting ", or", and by adding at the end the following new subparagraph:

"(BB) section 6050T(d) (relating to returns relating to payments for qualified health insurance).".

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

"Sec. 6050T. Returns relating to payments for qualified health insurance.".

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ", or from section 35 of such Code".

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

"Sec. 35. Health insurance costs.
"Sec. 36. Overpayments of tax.".

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

SEC. 102. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

"SEC. 7527. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

''(a) GENERAL RULE.—In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

''(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

''(1) who purchases qualified health insurance (as defined in section 35(c)), and

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

''(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which—

''(1) certifies that the individual will be eligible to receive the credit provided by section 35 for the taxable year,

''(2) estimates the amount of such credit for such taxable year, and

''(3) provides such other information as the Secretary may require for purposes of this section.

''(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the Secretary's estimate of the amount of credit allowable under section 35 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

''Sec. 7527. Advance payment of health insurance credit for purchasers of qualified health insurance.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2002.

TITLE II—ASSURING HEALTH INSURANCE COVERAGE FOR UNINSURABLE INDIVIDUALS

SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE SAFETY NETS.

(a) IN GENERAL.—

(1) REQUIREMENT.—For years beginning with 2002, each health insurer, health maintenance organization, and health service organization shall be a participant in a health insurance safety net (in this title referred to as a ''safety net'') established by the State in which it operates.

(2) FUNCTIONS.—Any safety net shall assure, in accordance with this title, the availability of qualified health insurance coverage to uninsurable individuals.

(3) FUNDING.—Any safety net shall be funded by an assessment against health insurers, health service organizations, and health maintenance organizations on a pro rata basis of premiums collected in the State in which the safety net operates. The costs of the assessment may be added by a health insurer, health service organization, or health maintenance organization to the costs of its health insurance or health coverage provided in the State.

(4) GUARANTEED RENEWABLE.—Coverage under a safety net shall be guaranteed renewable except for nonpayment of premiums, material misrepresentation, fraud, medicare eligibility under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), loss of dependent status, or eligibility for other health insurance coverage.

(5) COMPLIANCE WITH NAIC MODEL ACT.—In the case of a State that has not established, as of the date of the enactment of this Act, a high risk pool or other comprehensive health insurance program that assures the availability of qualified health insurance coverage to all eligible individuals residing in the State, a safety net shall be established in accordance with the requirements of the ''Model Health Plan For Uninsurable Individuals Act'' (or the successor model Act), as adopted by the National Association of Insurance Commissioners and as in effect on the date of the safety net's establishment.

(b) DEADLINE.—Safety nets required under subsection (a) shall be established not later than January 1, 2002.

(c) WAIVER.—This title shall not apply in the case of insurers and organizations operating in a State if the

State has established a similar comprehensive health insurance program that assures the availability of qualified health insurance coverage to all eligible individuals residing in the State.

(d) RECOMMENDATION FOR COMPLIANCE REQUIREMENT.—Not later than January 1, 2003, the Secretary of Health and Human Services shall submit to Congress a recommendation on appropriate sanctions for States that fail to meet the requirement of subsection (a).

SEC. 202. UNINSURABLE INDIVIDUALS ELIGIBLE FOR COVERAGE.

(a) UNINSURABLE AND ELIGIBLE INDIVIDUAL DEFINED.—In this title:

(1) UNINSURABLE INDIVIDUAL.—The term ''uninsurable individual'' means, with respect to a State, an eligible individual who presents proof of uninsurability by a private insurer in accordance with subsection (b) or proof of a condition previously recognized as uninsurable by the State.

(2) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term ''eligible individual'' means, with respect to a State, a citizen or national of the United States (or an alien lawfully admitted for permanent residence) who is a resident of the State for at least 90 days

and includes any dependent (as defined for purposes of the Internal Revenue Code of 1986) of such a citizen, national, or alien who also is such a resident.

(B) EXCEPTION.—An individual is not an ''eligible individual'' if the individual—

(i) is covered by or eligible for benefits under a State medicaid plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.),

(ii) has voluntarily terminated safety net coverage within the past 6 months,

(iii) has received the maximum benefit payable under the safety net,

(iv) is an inmate in a public institution, or

(v) is eligible for other public or private health care programs (including programs that pay for directly, or reimburse, otherwise eligible individuals with premiums charged for safety net coverage).

(b) PROOF OF UNINSURABILITY.—

(1) IN GENERAL.—The proof of uninsurability for an individual shall be in the form of—

(A) a notice of rejection or refusal to issue substantially similar health insurance for health reasons by one insurer; or

(B) a notice of refusal by an insurer to issue substantially similar health insurance except at a rate in excess of the rate applicable to the individual under the safety net plan.

For purposes of this paragraph, the term ''health insurance'' does not include insurance consisting only of stoploss, excess of loss, or reinsurance coverage.

(2) EXCEPTION FOR INDIVIDUALS WITH UNINSURABLE CONDITIONS.—The State shall promulgate a list of medical or health conditions for which an individual shall be eligible for safety net plan coverage without applying for health insurance or establishing proof of uninsurability under paragraph (1). Individuals who can demonstrate the existence or history of any medical or health conditions on such list shall not be required to provide the proof described in paragraph (1). The list shall be effective on the first day of the operation of the safety net plan and may be amended from time to time as may be appropriate.

SEC. 203. QUALIFIED HEALTH INSURANCE COVERAGE UNDER SAFETY NET.

In this title, the term ''qualified health insurance coverage'' means, with respect to a State, health insurance coverage that provides benefits typical of major medical insurance available in the individual health insurance market in such State.

SEC. 204. FUNDING OF SAFETY NET.

(a) LIMITATIONS ON PREMIUMS.—

(1) IN GENERAL.—The premium established under a safety net may not exceed 125 percent of the applicable standard risk rate, except as provided in paragraph (2).

(2) SURCHARGE FOR AVOIDABLE HEALTH RISKS.—A safety net may impose a surcharge on premiums for individuals with avoidable high risks, such as smoking.

(b) ADDITIONAL FUNDING.—A safety net shall provide for additional funding through an assessment on all health insurers, health service organizations, and health maintenance organizations in the State through a nonprofit association consisting of all such insurers and organizations doing business in the State on an equitable and pro rata basis consistent with section 201.

SEC. 205. ADMINISTRATION.

A safety net in a State shall be administered through a contract with 1 or more insurers or third party administrators operating in the State.

SEC. 206. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to reimburse States for their costs in administering this title.

TITLE III—INDIVIDUAL MEMBERSHIP ASSOCIATIONS

SEC. 301. EXPANSION OF ACCESS AND CHOICE THROUGH INDIVIDUAL MEMBERSHIP ASSOCIATIONS (IMAs).

The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—INDIVIDUAL MEMBERSHIP ASSOCIATIONS

''SEC. 2801. DEFINITION OF INDIVIDUAL MEMBERSHIP ASSOCIATION (IMA).

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

''(1) ORGANIZATION.—The IMA is an organization operated under the direction of an association (as defined in section 2804(1)).

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) DIFFERENT GROUPS.—The IMA, in conjunction with those health insurance issuers that offer health benefits coverage through the IMA, makes available health benefits coverage in the manner described in subsection (b) to all members of the IMA and the dependents of such members in the manner described in subsection (c)(2) at rates that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law.

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

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

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

preventing a health insurance issuer from excluding or limiting the coverage on any individual, subject to the requirement of section 2741.

''(C) NO FINANCIAL UNDERWRITING.—The IMA provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

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

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The IMA may provide administrative services for members. Such services may include accounting, billing, and enrollment information.

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

''(5) FILING INFORMATION.—The IMA files with the Secretary information that demonstrates the IMA's compliance with the applicable requirements of this title.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through an IMA shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law,

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(2), and

''(iii) offers the coverage under a contract with the IMA; and

''(B) subject to paragraph (2) and section 2902(2), be approved or otherwise permitted to be offered under State law.

''(2) EXAMPLES OF TYPES OF COVERAGE.—The benefits coverage made available through an IMA may include, but is not limited to, any of the fol-

lowing if it meets the other applicable requirements of this title:

"(A) Coverage through a health maintenance organization.

"(B) Coverage in connection with a preferred provider organization.

"(C) Coverage in connection with a licensed provider-sponsored organization.

"(D) Indemnity coverage through an insurance company.

"(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

"(F) Coverage that includes a point-of-service option.

"(G) Any combination of such types of coverage.

"(3) HEALTH INSURANCE COVERAGE OPTIONS.—An IMA shall include a minimum of 2 health insurance coverage options. At least 1 option shall meet all applicable State benefit mandates.

"(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through an IMA from establishing

premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the IMA and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to an individual who is a member of an IMA, the individual may apply for health benefits coverage (including coverage for dependents of such individual) offered by a health insurance issuer through the IMA.

''(B) RULES FOR ENROLLMENT.—Nothing in this paragraph shall preclude an IMA from establishing rules of enrollment and reenrollment of members. Such rules shall be applied consistently to all members within the IMA and shall not be based in any manner on health status-related factors.

''(2) HEALTH INSURANCE ISSUERS.—The contract between an IMA and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the IMA, for the payment of the premiums collected by the issuer.

"SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through an IMA:

''(1) Benefit requirements for health benefits coverage offered through an IMA, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through an

IMA, if the IMA meets the requirements of this title.

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

"SEC. 2803. ADMINISTRATION.

''(a) IN GENERAL.—The Secretary shall administer this title and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The Secretary shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(5)(A) and shall determine whether information filed by an IMA demonstrates compliance with the applicable requirements of this title. The Secretary shall exercise authority under this title in a manner that fosters and promotes the development of IMAs in order to improve access to health care coverage and services.

''(b) PERIODIC REPORTS.—The Secretary shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the Secretary to carry out this title, on the effectiveness of this title in promoting coverage of un-

insured individuals. The Secretary 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) ASSOCIATION.—The term 'association' means, with respect to health insurance coverage offered in a State, an association which—

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

"(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

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

"(D) does not make health insurance coverage offered through the association available other than in connection with a member of the association.

"(2) DEPENDENT.—The term 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regu-

lated) in a State, shall have the meaning applied to such term with respect to such coverage under the laws of the State relating to such coverage and such an issuer. Such term may include the spouse and children of the individual involved.

''(3) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term health insurance coverage in section 2791(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2).

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

''(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIATION.—The terms 'IMA' and 'individual membership association' are defined in section 2801(a).

''(7) MEMBER.—The term 'member' means, with respect to an IMA, an individual who is a member of the association to which the IMA is offering coverage.''.

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