

111TH CONGRESS
2^D SESSION

H. R. 5421

To repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, repeal the 7.5 percent threshold on the deduction for medical expenses, provide for increased funding for high-risk pools, allow acquiring health insurance across State lines, and allow for the creation of association health plans.

IN THE HOUSE OF REPRESENTATIVES

MAY 27, 2010

Mr. BROUN of Georgia (for himself and Mr. SHADEGG) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Appropriations, Ways and Means, Education and Labor, the Judiciary, Natural Resources, Rules, and House Administration, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, repeal the 7.5 percent threshold on the deduction for medical expenses, provide for increased funding for high-risk pools, allow acquiring health insurance across State lines, and allow for the creation of association health plans.

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

1 **SECTION 1. TABLE OF CONTENTS.**

2 The table of contents for this Act is as follows:

Sec. 1. Table of contents.

TITLE I—REPEAL OF PPACA AND HCERA

Sec. 101. Repeal of PPACA and HCERA.

TITLE II—DEDUCTIBILITY OF MEDICAL EXPENSES

Sec. 201. Repeal of 7.5 percent threshold on deduction for medical expenses.

TITLE III—UNIVERSAL ACCESS

Sec. 301. Increased funding for high risk pools.

TITLE IV—INTERSTATE PURCHASING OF HEALTH INSURANCE

Sec. 401. Interstate purchasing of health insurance.

TITLE V—ASSOCIATION HEALTH PLANS

- Sec. 501. Rules governing association health plans.
- Sec. 502. Clarification of treatment of single employer arrangements.
- Sec. 503. Enforcement provisions relating to association health plans.
- Sec. 504. Cooperation between Federal and State authorities.
- Sec. 505. Effective date and transitional and other rules.

3 **TITLE I—REPEAL OF PPACA AND**
4 **HCERA**

5 **SEC. 101. REPEAL OF PPACA AND HCERA.**

6 The Patient Protection and Affordable Care Act and
7 the Health Care and Education Reconciliation Act of 2010
8 are each repealed, effective as of the respective date of
9 enactment of each such Act, and the provisions of law
10 amended or repealed by such Acts are restored or revived
11 as if such Acts had not been enacted.

1 **TITLE II—DEDUCTIBILITY OF**
2 **MEDICAL EXPENSES**

3 **SEC. 201. REPEAL OF 7.5 PERCENT THRESHOLD ON DEDUC-**
4 **TION FOR MEDICAL EXPENSES.**

5 (a) **IN GENERAL.**—Subsection (a) of section 213 of
6 the Internal Revenue Code of 1986 (relating to deduction
7 for medical expenses) is amended by striking “to the ex-
8 tent that such expenses exceed 7.5 percent of adjusted
9 gross income”.

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

13 **TITLE III—UNIVERSAL ACCESS**

14 **SEC. 301. INCREASED FUNDING FOR HIGH RISK POOLS.**

15 (a) **IN GENERAL.**—Section 2745(d)(2) of the Public
16 Health Service Act (42 U.S.C. 300gg–45(d)(2)) is amend-
17 ed—

18 (1) in the heading, by striking “2010” and in-
19 sserting “2015”; and

20 (2) by inserting after “2010,” the following:
21 “and \$5,000,000,000 in each of fiscal years 2011
22 through 2015”.

23 (b) **EFFECTIVE DATE.**—The amendments made by
24 subsection (a) shall take effect on January 1, 2011.

1 **TITLE IV—INTERSTATE PUR-**
2 **CHASING OF HEALTH INSUR-**
3 **ANCE**

4 **SEC. 401. INTERSTATE PURCHASING OF HEALTH INSUR-**
5 **ANCE.**

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

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

11 **“SEC. 2795. DEFINITIONS.**

12 “In this part:

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

1 spect to such designated State, the issuer is deemed
2 to be doing business in that State.

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

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

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

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

1 ignated by the State to enforce the requirements of
2 this title for the State with respect to the issuer.

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

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

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

13 “(7) COVERED LAWS.—

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

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

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

24 “(iii) the provision to an individual in
25 relation to individual health insurance cov-

1 erage of health care and insurance related
2 services;

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

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

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

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

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

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

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

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

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

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

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

22 “(G) A pattern or practice of compelling
23 insured individuals or their beneficiaries to in-
24 stitute suits to recover amounts due under its
25 policies by offering substantially less than the

1 amounts ultimately recovered in suits brought
2 by them.

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

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

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

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

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

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

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

10 “(ii) The rating of an insurance policy
11 or reinsurance contract.

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

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

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

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

23 “(vii) The financial condition of an in-
24 surer or reinsurer.

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

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

8 “(x) The reinstatement of an insur-
9 ance policy.

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

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

21 “(D) Attempt to commit, aiding or abet-
22 ting in the commission of, or conspiracy to com-
23 mit the acts or omissions specified in this para-
24 graph.

1 **“SEC. 2796. APPLICATION OF LAW.**

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

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

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

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

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

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

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

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

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

23 “(i) in a delinquency proceeding com-
24 menced by the State insurance commis-
25 sioner if there has been a finding of finan-

1 cial impairment under subparagraph (C);

2 or

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

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

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

15 “(G) to comply with any State law regard-
16 ing fraud and abuse (as defined in section
17 2795(10)), except that if the State seeks an in-
18 junction regarding the conduct described in this
19 subparagraph, such injunction must be obtained
20 from a court of competent jurisdiction;

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

24 “(I) to comply with the applicable require-
25 ments for independent review under section

1 2798 with respect to coverage offered in the
2 State;

3 “(2) require any individual health insurance
4 coverage issued by the issuer to be countersigned by
5 an insurance agent or broker residing in that Sec-
6 ondary State; or

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

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

20 ‘This policy is issued by _____ and is governed by the
21 laws and regulations of the State of _____, and it
22 has met all the laws of that State as determined by that
23 State’s Department of Insurance. This policy may be less
24 expensive than others because it is not subject to all of
25 the insurance laws and regulations of the State of

1 _____, including coverage of some services or bene-
 2 fits mandated by the law of the State of _____. Ad-
 3 ditionally, this policy is not subject to all of the consumer
 4 protection laws or restrictions on rate changes of the State
 5 of _____. As with all insurance products, before pur-
 6 chasing this policy, you should carefully review the policy
 7 and determine what health care services the policy covers
 8 and what benefits it provides, including any exclusions,
 9 limitations, or conditions for such services or benefits.’

10 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
 11 AND PREMIUM INCREASES.—

12 “(1) IN GENERAL.—For purposes of this sec-
 13 tion, a health insurance issuer that provides indi-
 14 vidual health insurance coverage to an individual
 15 under this part in a primary or secondary State may
 16 not upon renewal—

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

22 “(B) increase the premiums assessed the
 23 individual for such coverage based on a health
 24 status-related factor or change of a health sta-

1 tus-related factor or the past or prospective
2 claim experience of the insured individual.

3 “(2) CONSTRUCTION.—Nothing in paragraph
4 (1) shall be construed to prohibit a health insurance
5 issuer—

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

9 “(B) from raising premium rates for all
10 policy holders within a class based on claims ex-
11 perience;

12 “(C) from changing premiums or offering
13 discounted premiums to individuals who engage
14 in wellness activities at intervals prescribed by
15 the issuer, if such premium changes or incen-
16 tives—

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

19 “(ii) are based on specific wellness ac-
20 tivities that are not applicable to all indi-
21 viduals; and

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

24 “(D) from reinstating lapsed coverage; or

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

5 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
6 STATE.—A health insurance issuer may not offer for sale
7 individual health insurance coverage in a secondary State
8 unless that coverage is currently offered for sale in the
9 primary State.

10 “(f) LICENSING OF AGENTS OR BROKERS FOR
11 HEALTH INSURANCE ISSUERS.—Any State may require
12 that a person acting, or offering to act, as an agent or
13 broker for a health insurance issuer with respect to the
14 offering of individual health insurance coverage obtain a
15 license from that State, with commissions or other com-
16 pensation subject to the provisions of the laws of that
17 State, except that a State may not impose any qualifica-
18 tion or requirement which discriminates against a non-
19 resident agent or broker.

20 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
21 SURANCE COMMISSIONER.—Each health insurance issuer
22 issuing individual health insurance coverage in both pri-
23 mary and secondary States shall submit—

24 “(1) to the insurance commissioner of each
25 State in which it intends to offer such coverage, be-

1 fore it may offer individual health insurance cov-
2 erage in such State—

3 “(A) a copy of the plan of operation or fea-
4 sibility study or any similar statement of the
5 policy being offered and its coverage (which
6 shall include the name of its primary State and
7 its principal place of business);

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

10 “(C) written notice from the issuer of the
11 issuer’s compliance with all the laws of the pri-
12 mary State; and

13 “(2) to the insurance commissioner of each sec-
14 ondary State in which it offers individual health in-
15 surance coverage, a copy of the issuer’s quarterly fi-
16 nancial statement submitted to the primary State,
17 which statement shall be certified by an independent
18 public accountant and contain a statement of opin-
19 ion on loss and loss adjustment expense reserves
20 made by—

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

23 “(B) a qualified loss reserve specialist.

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

4 “(1) the solicitation or sale of individual health
5 insurance coverage by a health insurance issuer to
6 any person or group who is not eligible for such in-
7 surance; or

8 “(2) the solicitation or sale of individual health
9 insurance coverage that violates the requirements of
10 the law of a secondary State which are described in
11 subparagraphs (A) through (H) of section
12 2796(b)(1).

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

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

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

1 “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

9 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
10 this section shall be construed to affect the applicability
11 of State laws generally applicable to persons or corpora-
12 tions.

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

1 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
2 **BEFORE ISSUER MAY SELL INTO SECONDARY**
3 **STATES.**

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

10 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
11 **DURES.**

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

16 “(1) both the secondary State and the primary
17 State have legislation or regulations in place estab-
18 lishing an independent review process for individuals
19 who are covered by individual health insurance cov-
20 erage, or

21 “(2) in any case in which the requirements of
22 subparagraph (A) are not met with respect to the ei-
23 ther of such States, the issuer provides an inde-
24 pendent review mechanism substantially identical (as
25 determined by the applicable State authority of such
26 State) to that prescribed in the ‘Health Carrier Ex-

1 ternal Review Model Act’ of the National Association
2 of Insurance Commissioners for all individuals who
3 purchase insurance coverage under the terms of this
4 part, except that, under such mechanism, the review
5 is conducted by an independent medical reviewer, or
6 a panel of such reviewers, with respect to whom the
7 requirements of subsection (b) are met.

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

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

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

18 “(B) with respect to each review, each re-
19 viewer meets the requirements of paragraph (4)
20 and the reviewer, or at least 1 reviewer on the
21 panel, meets the requirements described in
22 paragraph (5); and

23 “(C) compensation provided by the issuer
24 to each reviewer is consistent with paragraph
25 (6).

1 “(2) LICENSURE AND EXPERTISE.—Each inde-
2 pendent medical reviewer shall be a physician
3 (allopathic or osteopathic) or health care profes-
4 sional who—

5 “(A) is appropriately credentialed or li-
6 censed in 1 or more States to deliver health
7 care services; and

8 “(B) typically treats the condition, makes
9 the diagnosis, or provides the type of treatment
10 under review.

11 “(3) INDEPENDENCE.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), each independent medical reviewer
14 in a case shall—

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

17 “(ii) not have a material familial, fi-
18 nancial, or professional relationship with
19 such a party; and

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

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

1 “(i) prohibit an individual, solely on
2 the basis of affiliation with the issuer,
3 from serving as an independent medical re-
4 viewer if—

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

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

10 “(III) the fact of such an affili-
11 ation is disclosed to the issuer and the
12 enrollee (or authorized representative)
13 and neither party objects; and

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

18 “(ii) prohibit an individual who has
19 staff privileges at the institution where the
20 treatment involved takes place from serv-
21 ing as an independent medical reviewer
22 merely on the basis of such affiliation if
23 the affiliation is disclosed to the issuer and
24 the enrollee (or authorized representative),
25 and neither party objects; or

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

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

7 “(A) IN GENERAL.—In a case involving
8 treatment, or the provision of items or serv-
9 ices—

10 “(i) by a physician, a reviewer shall be
11 a practicing physician (allopathic or osteo-
12 pathic) of the same or similar specialty, as
13 a physician who, acting within the appro-
14 priate scope of practice within the State in
15 which the service is provided or rendered,
16 typically treats the condition, makes the
17 diagnosis, or provides the type of treat-
18 ment under review; or

19 “(ii) by a non-physician health care
20 professional, the reviewer, or at least 1
21 member of the review panel, shall be a
22 practicing non-physician health care pro-
23 fessional of the same or similar specialty
24 as the non-physician health care profes-
25 sional who, acting within the appropriate

1 scope of practice within the State in which
2 the service is provided or rendered, typi-
3 cally treats the condition, makes the diag-
4 nosis, or provides the type of treatment
5 under review.

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

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

16 “(6) LIMITATIONS ON REVIEWER COMPENSA-
17 TION.—Compensation provided by the issuer to an
18 independent medical reviewer in connection with a
19 review under this section shall—

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

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

23 “(7) RELATED PARTY DEFINED.—For purposes
24 of this section, the term ‘related party’ means, with

1 respect to a denial of a claim under a coverage relat-
2 ing to an enrollee, any of the following:

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

5 “(B) The enrollee (or authorized represent-
6 ative).

7 “(C) The health care professional that pro-
8 vides the items or services involved in the de-
9 nial.

10 “(D) The institution at which the items or
11 services (or treatment) involved in the denial
12 are provided.

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

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

19 “(8) DEFINITIONS.—For purposes of this sub-
20 section:

21 “(A) ENROLLEE.—The term ‘enrollee’
22 means, with respect to health insurance cov-
23 erage offered by a health insurance issuer, an
24 individual enrolled with the issuer to receive
25 such coverage.

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

7 **“SEC. 2799. ENFORCEMENT.**

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

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

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

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

1 secondary State may notify the applicable State authority
2 of the primary State.”.

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

7 (c) GAO ONGOING STUDY AND REPORTS.—

8 (1) STUDY.—The Comptroller General of the
9 United States shall conduct an ongoing study con-
10 cerning the effect of the amendment made by sub-
11 section (a) on—

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

14 (B) the availability and cost of health in-
15 surance policies for individuals with preexisting
16 medical conditions;

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

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

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

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

6 **TITLE V—ASSOCIATION HEALTH**
 7 **PLANS**

8 **SEC. 501. RULES GOVERNING ASSOCIATION HEALTH**
 9 **PLANS.**

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

13 **“PART 8—RULES GOVERNING ASSOCIATION**
 14 **HEALTH PLANS**

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

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

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

22 “(1) is organized and maintained in good faith,
 23 with a constitution and bylaws specifically stating its
 24 purpose and providing for periodic meetings on at
 25 least an annual basis, as a bona fide trade associa-

1 tion, a bona fide industry association (including a
2 rural electric cooperative association or a rural tele-
3 phone cooperative association), a bona fide profes-
4 sional association, or a bona fide chamber of com-
5 merce (or similar bona fide business association, in-
6 cluding a corporation or similar organization that
7 operates on a cooperative basis (within the meaning
8 of section 1381 of the Internal Revenue Code of
9 1986)), for substantial purposes other than that of
10 obtaining or providing medical care;

11 “(2) is established as a permanent entity which
12 receives the active support of its members and re-
13 quires for membership payment on a periodic basis
14 of dues or payments necessary to maintain eligibility
15 for membership in the sponsor; and

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

23 Any sponsor consisting of an association of entities which
24 meet the requirements of paragraphs (1), (2), and (3)

1 shall be deemed to be a sponsor described in this sub-
2 section.

3 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
4 **PLANS.**

5 “(a) IN GENERAL.—The applicable authority shall
6 prescribe by regulation a procedure under which, subject
7 to subsection (b), the applicable authority shall certify as-
8 sociation health plans which apply for certification as
9 meeting the requirements of this part.

10 “(b) STANDARDS.—Under the procedure prescribed
11 pursuant to subsection (a), in the case of an association
12 health plan that provides at least one benefit option which
13 does not consist of health insurance coverage, the applica-
14 ble authority shall certify such plan as meeting the re-
15 quirements of this part only if the applicable authority is
16 satisfied that the applicable requirements of this part are
17 met (or, upon the date on which the plan is to commence
18 operations, will be met) with respect to the plan.

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

1 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
2 CATION.—The applicable authority may provide by regula-
3 tion for continued certification of association health plans
4 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 this Act,

22 “(2) a plan under which the sponsor does not
23 restrict membership to one or more trades and busi-
24 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, consisting of any of the fol-
6 lowing: agriculture; equipment and automobile deal-
7 erships; barbering and cosmetology; certified public
8 accounting practices; child care; construction; dance,
9 theatrical and orchestra productions; disinfecting
10 and pest control; financial services; fishing; food
11 service establishments; hospitals; labor organiza-
12 tions; logging; manufacturing (metals); mining; med-
13 ical and dental practices; medical laboratories; pro-
14 fessional consulting services; sanitary services; trans-
15 portation (local and freight); warehousing; whole-
16 saling/distributing; or any other trade or business or
17 industry which has been indicated as having average
18 or above-average risk or health claims experience by
19 reason of State rate filings, denials of coverage, pro-
20 posed premium rate levels, or other means dem-
21 onstrated by such plan in accordance with regula-
22 tions.

1 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
2 **BOARDS OF TRUSTEES.**

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

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

12 “(1) FISCAL CONTROL.—The plan is operated,
13 pursuant to a trust agreement, by a board of trust-
14 ees which has complete fiscal control over the plan
15 and which is responsible for all operations of the
16 plan.

17 “(2) RULES OF OPERATION AND FINANCIAL
18 CONTROLS.—The board of trustees has in effect
19 rules of operation and financial controls, based on a
20 3-year plan of operation, adequate to carry out the
21 terms of the plan and to meet all requirements of
22 this title applicable to the plan.

23 “(3) RULES GOVERNING RELATIONSHIP TO
24 PARTICIPATING EMPLOYERS AND TO CONTRAC-
25 TORS.—

26 “(A) BOARD MEMBERSHIP.—

1 “(i) IN GENERAL.—Except as pro-
2 vided in clauses (ii) and (iii), the members
3 of the board of trustees are individuals se-
4 lected from individuals who are the owners,
5 officers, directors, or employees of the par-
6 ticipating employers or who are partners in
7 the participating employers and actively
8 participate in the business.

9 “(ii) LIMITATION.—

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

16 “(II) LIMITED EXCEPTION FOR
17 PROVIDERS OF SERVICES SOLELY ON
18 BEHALF OF THE SPONSOR.—Officers
19 or employees of a sponsor which is a
20 service provider (other than a contract
21 administrator) to the plan may be
22 members of the board if they con-
23 stitute not more than 25 percent of
24 the membership of the board and they

1 do not provide services to the plan
2 other than on behalf of the sponsor.

3 “(III) TREATMENT OF PRO-
4 VIDERS OF MEDICAL CARE.—In the
5 case of a sponsor which is an associa-
6 tion whose membership consists pri-
7 marily of providers of medical care,
8 subclause (I) shall not apply in the
9 case of any service provider described
10 in subclause (I) who is a provider of
11 medical care under the plan.

12 “(iii) CERTAIN PLANS EXCLUDED.—
13 Clause (i) shall not apply to an association
14 health plan which is in existence on the
15 date of the enactment of this Act.

16 “(B) SOLE AUTHORITY.—The board has
17 sole authority under the plan to approve appli-
18 cations for participation in the plan and to con-
19 tract with a service provider to administer the
20 day-to-day affairs of the plan.

21 “(c) TREATMENT OF FRANCHISE NETWORKS.—In
22 the case of a group health plan which is established and
23 maintained by a franchiser for a franchise network con-
24 sisting of its franchisees—

1 “(1) the requirements of subsection (a) and sec-
 2 tion 801(a) shall be deemed met if such require-
 3 ments would otherwise be met if the franchiser were
 4 deemed to be the sponsor referred to in section
 5 801(b), such network were deemed to be an associa-
 6 tion described in section 801(b), and each franchisee
 7 were deemed to be a member (of the association and
 8 the sponsor) referred to in section 801(b); and

9 “(2) the requirements of section 804(a)(1) shall
 10 be deemed met.

11 The Secretary may by regulation define for purposes of
 12 this subsection the terms ‘franchiser’, ‘franchise network’,
 13 and ‘franchisee’.

14 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
 15 **MENTS.**

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

20 “(1) each participating employer must be—

21 “(A) a member of the sponsor,

22 “(B) the sponsor, or

23 “(C) an affiliated member of the sponsor

24 with respect to which the requirements of sub-

25 section (b) are met,

1 except that, in the case of a sponsor which is a pro-
2 fessional association or other individual-based asso-
3 ciation, if at least one of the officers, directors, or
4 employees of an employer, or at least one of the in-
5 dividuals who are partners in an employer and who
6 actively participates in the business, is a member or
7 such an affiliated member of the sponsor, partici-
8 pating employers may also include such employer;
9 and

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

13 “(A) active or retired owners (including
14 self-employed individuals), officers, directors, or
15 employees of, or partners in, participating em-
16 ployers; or

17 “(B) the beneficiaries of individuals de-
18 scribed in subparagraph (A).

19 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
20 PLOYEES.—In the case of an association health plan in
21 existence on the date of the enactment of this Act, an af-
22 filiated member of the sponsor of the plan may be offered
23 coverage under the plan as a participating employer only
24 if—

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

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

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

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

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

9 “(2) upon request, any employer eligible to par-
10 ticipate is furnished information regarding all cov-
11 erage options available under the plan; and

12 “(3) the applicable requirements of sections
13 701, 702, and 703 are met with respect to the plan.

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

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

20 “(1) CONTENTS OF GOVERNING INSTRU-
21 MENTS.—The instruments governing the plan in-
22 clude a written instrument, meeting the require-
23 ments of an instrument required under section
24 402(a)(1), which—

1 “(A) provides that the board of trustees
2 serves as the named fiduciary required for plans
3 under section 402(a)(1) and serves in the ca-
4 pacity of a plan administrator (referred to in
5 section 3(16)(A));

6 “(B) provides that the sponsor of the plan
7 is to serve as plan sponsor (referred to in sec-
8 tion 3(16)(B)); and

9 “(C) incorporates the requirements of sec-
10 tion 806.

11 “(2) CONTRIBUTION RATES MUST BE NON-
12 DISCRIMINATORY.—

13 “(A) The contribution rates for any par-
14 ticipating small employer do not vary on the
15 basis of any health status-related factor in rela-
16 tion to employees of such employer or their
17 beneficiaries and do not vary on the basis of the
18 type of business or industry in which such em-
19 ployer is engaged.

20 “(B) Nothing in this title or any other pro-
21 vision of law shall be construed to preclude an
22 association health plan, or a health insurance
23 issuer offering health insurance coverage in
24 connection with an association health plan,
25 from—

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

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

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

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

21 “(4) MARKETING REQUIREMENTS.—

22 “(A) IN GENERAL.—If a benefit option
23 which consists of health insurance coverage is
24 offered under the plan, State-licensed insurance
25 agents shall be used to distribute to small em-

1 employers coverage which does not consist of
2 health insurance coverage in a manner com-
3 parable to the manner in which such agents are
4 used to distribute health insurance coverage.

5 “(B) STATE-LICENSED INSURANCE
6 AGENTS.—For purposes of subparagraph (A),
7 the term ‘State-licensed insurance agents’
8 means one or more agents who are licensed in
9 a State and are subject to the laws of such
10 State relating to licensure, qualification, test-
11 ing, examination, and continuing education of
12 persons authorized to offer, sell, or solicit
13 health insurance coverage in such State.

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

19 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
20 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
21 nothing in this part or any provision of State law (as de-
22 fined in section 514(e)(1)) shall be construed to preclude
23 an association health plan, or a health insurance issuer
24 offering health insurance coverage in connection with an
25 association health plan, from exercising its sole discretion

1 in selecting the specific items and services consisting of
2 medical care to be included as benefits under such plan
3 or coverage, except (subject to section 514) in the case
4 of (1) any law to the extent that it is not preempted under
5 section 731(a)(1) with respect to matters governed by sec-
6 tion 711, 712, or 713, or (2) any law of the State with
7 which filing and approval of a policy type offered by the
8 plan was initially obtained to the extent that such law pro-
9 hibits an exclusion of a specific disease from such cov-
10 erage.

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

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

17 “(1) the benefits under the plan consist solely
18 of health insurance coverage; or

19 “(2) if the plan provides any additional benefit
20 options which do not consist of health insurance cov-
21 erage, the plan—

22 “(A) establishes and maintains reserves
23 with respect to such additional benefit options,
24 in amounts recommended by the qualified actu-
25 ary, consisting of—

1 “(i) a reserve sufficient for unearned
2 contributions;

3 “(ii) a reserve sufficient for benefit li-
4 abilities which have been incurred, which
5 have not been satisfied, and for which risk
6 of loss has not yet been transferred, and
7 for expected administrative costs with re-
8 spect to such benefit liabilities;

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

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

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

20 “(i) The plan shall secure aggregate
21 excess/stop loss insurance for the plan with
22 an attachment point which is not greater
23 than 125 percent of expected gross annual
24 claims. The applicable authority may by
25 regulation provide for upward adjustments

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

6 “(ii) The plan shall secure specific ex-
7 cess/stop loss insurance for the plan with
8 an attachment point which is at least equal
9 to an amount recommended by the plan’s
10 qualified actuary. The applicable authority
11 may by regulation provide for adjustments
12 in the amount of such insurance in speci-
13 fied circumstances in which the plan spe-
14 cifically provides for and maintains re-
15 serves in excess of the amounts required
16 under subparagraph (A).

17 “(iii) The plan shall secure indem-
18 nification insurance for any claims which
19 the plan is unable to satisfy by reason of
20 a plan termination.

21 Any person issuing to a plan insurance described in clause
22 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-
23 retary of any failure of premium payment meriting can-
24 cellation of the policy prior to undertaking such a cancella-
25 tion. Any regulations prescribed by the applicable author-

1 ity pursuant to clause (i) or (ii) of subparagraph (B) may
2 allow for such adjustments in the required levels of excess/
3 stop loss insurance as the qualified actuary may rec-
4 ommend, taking into account the specific circumstances
5 of the plan.

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

11 “(1) \$500,000, or

12 “(2) such greater amount (but not greater than
13 \$2,000,000) as may be set forth in regulations pre-
14 scribed by the applicable authority, considering the
15 level of aggregate and specific excess/stop loss insur-
16 ance provided with respect to such plan and other
17 factors related to solvency risk, such as the plan’s
18 projected levels of participation or claims, the nature
19 of the plan’s liabilities, and the types of assets avail-
20 able to assure that such liabilities are met.

21 “(c) ADDITIONAL REQUIREMENTS.—In the case of
22 any association health plan described in subsection (a)(2),
23 the applicable authority may provide such additional re-
24 quirements relating to reserves, excess/stop loss insurance,
25 and indemnification insurance as the applicable authority

1 considers appropriate. Such requirements may be provided
2 by regulation with respect to any such plan or any class
3 of such plans.

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

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

1 applicable terms of the plan in the form of assessments
2 of participating employers, security, or other financial ar-
3 rangement.

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

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

8 “(A) IN GENERAL.—In the case of an as-
9 sociation health plan described in subsection
10 (a)(2), the requirements of this subsection are
11 met if the plan makes payments into the Asso-
12 ciation Health Plan Fund under this subpara-
13 graph when they are due. Such payments shall
14 consist of annual payments in the amount of
15 \$5,000, and, in addition to such annual pay-
16 ments, such supplemental payments as the Sec-
17 retary may determine to be necessary under
18 paragraph (2). Payments under this paragraph
19 are payable to the Fund at the time determined
20 by the Secretary. Initial payments are due in
21 advance of certification under this part. Pay-
22 ments shall continue to accrue until a plan’s as-
23 sets are distributed pursuant to a termination
24 procedure.

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

7 “(C) CONTINUED DUTY OF THE SEC-
8 RETARY.—The Secretary shall not cease to
9 carry out the provisions of paragraph (2) on ac-
10 count of the failure of a plan to pay any pay-
11 ment when due.

12 “(2) PAYMENTS BY SECRETARY TO CONTINUE
13 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
14 DEMNIFICATION INSURANCE COVERAGE FOR CER-
15 TAIN PLANS.—In any case in which the applicable
16 authority determines that there is, or that there is
17 reason to believe that there will be: (A) a failure to
18 take necessary corrective actions under section
19 809(a) with respect to an association health plan de-
20 scribed in subsection (a)(2); or (B) a termination of
21 such a plan under section 809(b) or 810(b)(8) (and,
22 if the applicable authority is not the Secretary, cer-
23 tifies such determination to the Secretary), the Sec-
24 retary shall determine the amounts necessary to
25 make payments to an insurer (designated by the

1 Secretary) to maintain in force excess/stop loss in-
2 surance coverage or indemnification insurance cov-
3 erage for such plan, if the Secretary determines that
4 there is a reasonable expectation that, without such
5 payments, claims would not be satisfied by reason of
6 termination of such coverage. The Secretary shall, to
7 the extent provided in advance in appropriation
8 Acts, pay such amounts so determined to the insurer
9 designated by the Secretary.

10 “(3) ASSOCIATION HEALTH PLAN FUND.—

11 “(A) IN GENERAL.—There is established
12 on the books of the Treasury a fund to be
13 known as the ‘Association Health Plan Fund’.
14 The Fund shall be available for making pay-
15 ments pursuant to paragraph (2). The Fund
16 shall be credited with payments received pursu-
17 ant to paragraph (1)(A), penalties received pur-
18 suant to paragraph (1)(B); and earnings on in-
19 vestments of amounts of the Fund under sub-
20 paragraph (B).

21 “(B) INVESTMENT.—Whenever the Sec-
22 retary determines that the moneys of the fund
23 are in excess of current needs, the Secretary
24 may request the investment of such amounts as
25 the Secretary determines advisable by the Sec-

1 retary of the Treasury in obligations issued or
2 guaranteed by the United States.

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

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

9 “(A) under which an insurer (meeting such
10 minimum standards as the applicable authority
11 may prescribe by regulation) provides for pay-
12 ment to the plan with respect to aggregate
13 claims under the plan in excess of an amount
14 or amounts specified in such contract;

15 “(B) which is guaranteed renewable; and

16 “(C) which allows for payment of pre-
17 miums by any third party on behalf of the in-
18 sured plan.

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

23 “(A) under which an insurer (meeting such
24 minimum standards as the applicable authority
25 may prescribe by regulation) provides for pay-

1 ment to the plan with respect to claims under
2 the plan in connection with a covered individual
3 in excess of an amount or amounts specified in
4 such contract in connection with such covered
5 individual;

6 “(B) which is guaranteed renewable; and

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

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

14 “(1) under which an insurer (meeting such min-
15 imum standards as the applicable authority may pre-
16 scribe by regulation) provides for payment to the
17 plan with respect to claims under the plan which the
18 plan is unable to satisfy by reason of a termination
19 pursuant to section 809(b) (relating to mandatory
20 termination);

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

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

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

7 “(j) SOLVENCY STANDARDS WORKING GROUP.—

8 “(1) IN GENERAL.—Within 90 days after the
9 date of the enactment of this Act, the applicable au-
10 thority shall establish a Solvency Standards Working
11 Group. In prescribing the initial regulations under
12 this section, the applicable authority shall take into
13 account the recommendations of such Working
14 Group.

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

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

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

1 “(C) a representative of the State govern-
2 ments, or their interests;

3 “(D) a representative of existing self-in-
4 sured arrangements, or their interests;

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

8 “(F) a representative of multiemployer
9 plans that are group health plans, or their in-
10 terests.

11 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
12 **LATED REQUIREMENTS.**

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

22 “(b) **INFORMATION TO BE INCLUDED IN APPLICA-**
23 **TION FOR CERTIFICATION.**—An application for certifi-
24 cation under this part meets the requirements of this sec-
25 tion only if it includes, in a manner and form which shall

1 be prescribed by the applicable authority by regulation, at
2 least the following information:

3 “(1) IDENTIFYING INFORMATION.—The names
4 and addresses of—

5 “(A) the sponsor; and

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

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

13 “(3) BONDING REQUIREMENTS.—Evidence pro-
14 vided by the board of trustees that the bonding re-
15 quirements of section 412 will be met as of the date
16 of the application or (if later) commencement of op-
17 erations.

18 “(4) PLAN DOCUMENTS.—A copy of the docu-
19 ments governing the plan (including any bylaws and
20 trust agreements), the summary plan description,
21 and other material describing the benefits that will
22 be provided to participants and beneficiaries under
23 the plan.

24 “(5) AGREEMENTS WITH SERVICE PRO-
25 VIDERS.—A copy of any agreements between the

1 plan and contract administrators and other service
2 providers.

3 “(6) FUNDING REPORT.—In the case of asso-
4 ciation health plans providing benefits options in ad-
5 dition to health insurance coverage, a report setting
6 forth information with respect to such additional
7 benefit options determined as of a date within the
8 120-day period ending with the date of the applica-
9 tion, including the following:

10 “(A) RESERVES.—A statement, certified
11 by the board of trustees of the plan, and a
12 statement of actuarial opinion, signed by a
13 qualified actuary, that all applicable require-
14 ments of section 806 are or will be met in ac-
15 cordance with regulations which the applicable
16 authority shall prescribe.

17 “(B) ADEQUACY OF CONTRIBUTION
18 RATES.—A statement of actuarial opinion,
19 signed by a qualified actuary, which sets forth
20 a description of the extent to which contribution
21 rates are adequate to provide for the payment
22 of all obligations and the maintenance of re-
23 quired reserves under the plan for the 12-
24 month period beginning with such date within
25 such 120-day period, taking into account the

1 expected coverage and experience of the plan. If
2 the contribution rates are not fully adequate,
3 the statement of actuarial opinion shall indicate
4 the extent to which the rates are inadequate
5 and the changes needed to ensure adequacy.

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

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

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

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

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

21 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
22 SOCIATION HEALTH PLANS.—An association health plan
23 certified under this part which provides benefit options in
24 addition to health insurance coverage for such plan year
25 shall meet the requirements of section 103 by filing an

1 annual report under such section which shall include infor-
2 mation described in subsection (b)(6) with respect to the
3 plan year and, notwithstanding section 104(a)(1)(A), shall
4 be filed with the applicable authority not later than 90
5 days after the close of the plan year (or on such later date
6 as may be prescribed by the applicable authority). The ap-
7 plicable authority may require by regulation such interim
8 reports as it considers appropriate.

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

22 “(1) are in the aggregate reasonably related to
23 the experience of the plan and to reasonable expecta-
24 tions; and

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

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

5 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
6 **MINATION.**

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

13 “(1) provides to the participants and bene-
14 ficiaries a written notice of intent to terminate stat-
15 ing that such termination is intended and the pro-
16 posed termination date;

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

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

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

1 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
2 **NATION.**

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

1 shall thereafter report to the applicable authority, in such
2 form and frequency as the applicable authority may speci-
3 fy to the board, regarding corrective action taken by the
4 board until the requirements of section 806 are met.

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

7 “(1) the applicable authority has been notified
8 under subsection (a) (or by an issuer of excess/stop
9 loss insurance or indemnity insurance pursuant to
10 section 806(a)) of a failure of an association health
11 plan which is or has been certified under this part
12 and is described in section 806(a)(2) to meet the re-
13 quirements of section 806 and has not been notified
14 by the board of trustees of the plan that corrective
15 action has restored compliance with such require-
16 ments; and

17 “(2) the applicable authority determines that
18 there is a reasonable expectation that the plan will
19 continue to fail to meet the requirements of section
20 806,

21 the board of trustees of the plan shall, at the direction
22 of the applicable authority, terminate the plan and, in the
23 course of the termination, take such actions as the appli-
24 cable authority may require, including satisfying any
25 claims referred to in section 806(a)(2)(B)(iii) and recov-

1 ering for the plan any liability under subsection
2 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
3 that the affairs of the plan will be, to the maximum extent
4 possible, wound up in a manner which will result in timely
5 provision of all benefits for which the plan is obligated.

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

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

1 avoid any unreasonable deterioration of the financial con-
2 dition of the plan. The trusteeship of such Secretary shall
3 continue until the conditions described in the first sen-
4 tence of this subsection are remedied or the plan is termi-
5 nated.

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

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

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

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

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

1 “(5) to collect for the plan any amounts due the
2 plan and to recover reasonable expenses of the trust-
3 eeship;

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

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

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

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

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

1 “(c) NOTICE OF APPOINTMENT.—As soon as prac-
2 ticable after the Secretary’s appointment as trustee, the
3 Secretary shall give notice of such appointment to—

4 “(1) the sponsor and plan administrator;

5 “(2) each participant;

6 “(3) each participating employer; and

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

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

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

24 “(f) JURISDICTION OF COURT.—

1 “(1) IN GENERAL.—Upon the filing of an appli-
2 cation for the appointment as trustee or the issuance
3 of a decree under this section, the court to which the
4 application is made shall have exclusive jurisdiction
5 of the plan involved and its property wherever lo-
6 cated with the powers, to the extent consistent with
7 the purposes of this section, of a court of the United
8 States having jurisdiction over cases under chapter
9 11 of title 11, United States Code. Pending an adju-
10 dication under this section such court shall stay, and
11 upon appointment by it of the Secretary as trustee,
12 such court shall continue the stay of, any pending
13 mortgage foreclosure, equity receivership, or other
14 proceeding to reorganize, conserve, or liquidate the
15 plan, the sponsor, or property of such plan or spon-
16 sor, and any other suit against any receiver, conser-
17 vator, or trustee of the plan, the sponsor, or prop-
18 erty of the plan or sponsor. Pending such adjudica-
19 tion and upon the appointment by it of the Sec-
20 retary as trustee, the court may stay any proceeding
21 to enforce a lien against property of the plan or the
22 sponsor or any other suit against the plan or the
23 sponsor.

24 “(2) VENUE.—An action under this section
25 may be brought in the judicial district where the

1 sponsor or the plan administrator resides or does
2 business or where any asset of the plan is situated.
3 A district court in which such action is brought may
4 issue process with respect to such action in any
5 other judicial district.

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

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

13 “(a) IN GENERAL.—Notwithstanding section 514, a
14 State may impose by law a contribution tax on an associa-
15 tion health plan described in section 806(a)(2), if the plan
16 commenced operations in such State after the date of the
17 enactment of this Act.

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

22 “(1) such tax is computed by applying a rate to
23 the amount of premiums or contributions, with re-
24 spect to individuals covered under the plan who are
25 residents of such State, which are received by the

1 plan from participating employers located in such
2 State or from such individuals;

3 “(2) the rate of such tax does not exceed the
4 rate of any tax imposed by such State on premiums
5 or contributions received by insurers or health main-
6 tenance organizations for health insurance coverage
7 offered in such State in connection with a group
8 health plan;

9 “(3) such tax is otherwise nondiscriminatory;
10 and

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

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

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

1 “(1) GROUP HEALTH PLAN.—The term ‘group
2 health plan’ has the meaning provided in section
3 733(a)(1) (after applying subsection (b) of this sec-
4 tion).

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

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

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

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

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

23 “(7) INDIVIDUAL MARKET.—

24 “(A) IN GENERAL.—The term ‘individual
25 market’ means the market for health insurance

1 coverage offered to individuals other than in
2 connection with a group health plan.

3 “(B) TREATMENT OF VERY SMALL
4 GROUPS.—

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

12 “(ii) STATE EXCEPTION.—Clause (i)
13 shall not apply in the case of health insur-
14 ance coverage offered in a State if such
15 State regulates the coverage described in
16 such clause in the same manner and to the
17 same extent as coverage in the small group
18 market (as defined in section 2791(e)(5) of
19 the Public Health Service Act) is regulated
20 by such State.

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

1 who is such employer (or any dependent, as defined
2 under the terms of the plan, of such individual) is
3 or was covered under such plan in connection with
4 the status of such individual as such an employee,
5 partner, or self-employed individual in relation to the
6 plan.

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

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

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

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

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

1 “(C) in the case of an association health
2 plan in existence on the date of the enactment
3 of this Act, a person eligible to be a member of
4 the sponsor or one of its member associations.

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

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

16 “(b) RULES OF CONSTRUCTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
23 CATION OF SELF-INSURED ASSOCIATION HEALTH
24 PLANS.—Not later than January 1, 2012, the Secretary
25 of Labor shall report to the Committee on Education and

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“801. Association health plans.

“802. Certification of association health plans.

“803. Requirements relating to sponsors and boards of trustees.

“804. Participation and coverage requirements.

“805. Other requirements relating to plan documents, contribution rates, and
 benefit options.

“806. Maintenance of reserves and provisions for solvency for plans providing
 health benefits in addition to health insurance coverage.

“807. Requirements for application and related requirements.

“808. Notice requirements for voluntary termination.

“809. Corrective actions and mandatory termination.

“810. Trusteeship by the Secretary of insolvent association health plans pro-
 viding health benefits in addition to health insurance coverage.

“811. State assessment authority.

“812. Definitions and rules of construction.”.

9 **SEC. 502. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 10 **PLOYER ARRANGEMENTS.**

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

14 (1) in clause (i), by inserting after “control
 15 group,” the following: “except that, in any case in
 16 which the benefit referred to in subparagraph (A)
 17 consists of medical care (as defined in section

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

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

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

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

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

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

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

19 **SEC. 503. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
20 **CIATION HEALTH PLANS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **SEC. 504. COOPERATION BETWEEN FEDERAL AND STATE**
5 **AUTHORITIES.**

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

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

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

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

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

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

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

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

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

13 **SEC. 505. EFFECTIVE DATE AND TRANSITIONAL AND**
 14 **OTHER RULES.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

○