

113TH CONGRESS  
1ST SESSION

# H. R. 3121

To repeal the Patient Protection and Affordable Care Act and related reconciliation provisions, to promote patient-centered health care, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 18, 2013

Mr. ROE of Tennessee (for himself, Mr. SCALISE, Mrs. BLACKBURN, Mrs. ELLMERS, Mr. FLEMING, Mr. GOSAR, Mr. PRICE of Georgia, Mr. ROKITA, Mr. FLORES, Mr. PEARCE, Mrs. HARTZLER, Mr. WALBERG, Mr. CULBERSON, Mr. WENSTRUP, Mr. MULVANEY, Mr. ROSS, Mr. STEWART, Mr. PALAZZO, Mr. LAMALFA, Mr. MCKINLEY, Mr. STOCKMAN, Mr. BUCSHON, Mr. COTTON, Mr. JORDAN, and Mr. SALMON) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, the Judiciary, Natural Resources, House Administration, Appropriations, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To repeal the Patient Protection and Affordable Care Act and related reconciliation provisions, to promote patient-centered health care, and for other purposes.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the  
3 “American Health Care Reform Act of 2013”.

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

Sec. 1. Short title; table of contents.

**TITLE I—REPEAL OF OBAMACARE**

Sec. 101. Repeal of PPACA and health care-related provisions in the Health Care and Education Reconciliation Act of 2010.

**TITLE II—INCREASING ACCESS TO PORTABLE, AFFORDABLE  
HEALTH INSURANCE**

Sec. 200. Amendment of 1986 Code.

**Subtitle A—Standard Deduction for Health Insurance**

Sec. 201. Standard deduction for health insurance.

Sec. 202. Changes to existing tax preferences for medical coverage and costs for individuals eligible for standard deduction for health insurance.

Sec. 203. Exclusion of standard deduction for health insurance from employment taxes.

Sec. 204. Information reporting.

Sec. 205. Election to disregard inclusion of contributions by employer to accident or health plan.

**Subtitle B—Enhancement of Health Savings Accounts**

Sec. 221. Allow both spouses to make catch-up contributions to the same HSA account.

Sec. 222. Provisions relating to Medicare.

Sec. 223. Individuals eligible for veterans benefits for a service-connected disability.

Sec. 224. Individuals eligible for Indian Health Service assistance.

Sec. 225. Individuals eligible for TRICARE coverage.

Sec. 226. FSA and HRA interaction with HSAs.

Sec. 227. Purchase of health insurance from HSA account.

Sec. 228. Special rule for certain medical expenses incurred before establishment of account.

Sec. 229. Preventive care prescription drug clarification.

Sec. 230. Equivalent bankruptcy protections for health savings accounts as retirement funds.

Sec. 231. Administrative error correction before due date of return.

Sec. 232. Reauthorization of Medicaid health opportunity accounts.

Sec. 233. Members of health care sharing ministries eligible to establish health savings accounts.

Sec. 234. High deductible health plans renamed HSA qualified plans.

Sec. 235. Treatment of direct primary care service arrangements.

- Sec. 236. Certain exercise equipment and physical fitness programs treated as medical care.
- Sec. 237. Certain nutritional and dietary supplements to be treated as medical care.
- Sec. 238. Certain provider fees to be treated as medical care.
- Sec. 239. Increase the maximum contribution limit to an HSA to match deductible and out-of-pocket expense limitation.
- Sec. 240. Child health savings account.
- Sec. 241. Distributions for abortion expenses from health savings accounts included in gross income.

Subtitle C—Enhanced Wellness Incentives

- Sec. 251. Providing financial incentives for treatment compliance.

TITLE III—IMPROVING ACCESS TO INSURANCE FOR VULNERABLE AMERICANS

Subtitle A—Eliminating Barriers to Insurance Coverage

- Sec. 301. Elimination of certain requirements for guaranteed availability in individual market.

Subtitle B—Ensuring Coverage for Individuals With Preexisting Conditions and Multiple Health Care Needs Through High Risk Pools

- Sec. 311. Improvement of high risk pools.

TITLE IV—ENCOURAGING A MORE COMPETITIVE HEALTH CARE MARKET

Subtitle A—Expanding Patient Choice

- Sec. 401. Cooperative governing of individual health insurance coverage.

Subtitle B—McCarran-Ferguson Reform

- Sec. 411. Restoring the application of antitrust laws to health sector insurers.

Subtitle C—Medicare Price Transparency

- Sec. 421. Public availability of Medicare claims data.

Subtitle D—State Transparency Portals

- Sec. 431. Providing information on health coverage options and health care providers.

Subtitle E—Protecting the Doctor-Patient Relationship

- Sec. 441. Rule of construction.
- Sec. 442. Repeal of Federal Coordinating Council for Comparative Effectiveness Research.

Subtitle F—Association Health Plans

- Sec. 451. Rules governing association health plans.
- Sec. 452. Clarification of treatment of single employer arrangements.
- Sec. 453. Enforcement provisions relating to association health plans.
- Sec. 454. Cooperation between Federal and State authorities.

Sec. 455. Effective date and transitional and other rules.

TITLE V—REFORMING MEDICAL LIABILITY LAW

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

TITLE VI—RESPECTING HUMAN LIFE

Sec. 601. Special rules regarding abortion.

1                   **TITLE I—REPEAL OF**  
 2                   **OBAMACARE**  
 3   **SEC. 101. REPEAL OF PPACA AND HEALTH CARE-RELATED**  
 4                   **PROVISIONS IN THE HEALTH CARE AND EDU-**  
 5                   **CATION RECONCILIATION ACT OF 2010.**

6           (a) PPACA.—Effective as of the enactment of the  
 7 Patient Protection and Affordable Care Act (Public Law  
 8 111–148), such Act is repealed, and the provisions of law  
 9 amended or repealed by such Act are restored or revived  
 10 as if such Act had not been enacted.

11           (b) HEALTH CARE-RELATED PROVISIONS IN THE  
 12 HEALTH CARE AND EDUCATION RECONCILIATION ACT OF  
 13 2010.—Effective as of the enactment of the Health Care  
 14 and Education Reconciliation Act of 2010 (Public Law  
 15 111–152), title I and subtitle B of title II of such Act  
 16 are repealed, and the provisions of law amended or re-  
 17 pealed by such title or subtitle, respectively, are restored

1 or revived as if such title and subtitle had not been en-  
2 acted.

3 **TITLE II—INCREASING ACCESS**  
4 **TO PORTABLE, AFFORDABLE**  
5 **HEALTH INSURANCE**

6 **SEC. 200. AMENDMENT OF 1986 CODE.**

7 Except as otherwise expressly provided, whenever in  
8 this title an amendment or repeal is expressed in terms  
9 of an amendment to, or repeal of, a section or other provi-  
10 sion, the reference shall be considered to be made to a  
11 section or other provision of the Internal Revenue Code  
12 of 1986.

13 **Subtitle A—Standard Deduction**  
14 **for Health Insurance**

15 **SEC. 201. STANDARD DEDUCTION FOR HEALTH INSUR-**  
16 **ANCE.**

17 (a) IN GENERAL.—Part VII of subchapter B of chap-  
18 ter 1 is amended by redesignating section 224 as section  
19 225 and by inserting after section 223 the following new  
20 section:

21 **“SEC. 224. STANDARD DEDUCTION FOR HEALTH INSUR-**  
22 **ANCE.**

23 “(a) DEDUCTION ALLOWED.—In the case of an indi-  
24 vidual, there shall be allowed as a deduction to the tax-

1 payer for the taxable year the standard deduction for  
2 health insurance.

3 “(b) STANDARD DEDUCTION FOR HEALTH INSUR-  
4 ANCE.—For purposes of this section—

5 “(1) IN GENERAL.—The term ‘standard deduc-  
6 tion for health insurance’ means the sum of the  
7 monthly limitations for months during the taxable  
8 year.

9 “(2) MONTHLY LIMITATION.—

10 “(A) IN GENERAL.—The monthly limita-  
11 tion for any month is  $\frac{1}{12}$  of—

12 “(i) \$20,000, in the case of a tax-  
13 payer who is allowed a deduction under  
14 section 151 for more than one individual  
15 who for such month is an eligible indi-  
16 vidual, and

17 “(ii) \$7,500, in the case of a taxpayer  
18 who is allowed a deduction under section  
19 151 for only one individual who for such  
20 month is an eligible individual.

21 “(B) COST-OF-LIVING ADJUSTMENT.—

22 “(i) IN GENERAL.—In the case of tax-  
23 able years beginning in calendar years  
24 after the first calendar year to which this  
25 section applies, the dollar amounts under

1                   subparagraph (A) shall be increased by an  
2                   amount equal to—

3                   “(I) such dollar amount, multi-  
4                   plied by

5                   “(II) the cost-of-living adjust-  
6                   ment determined under section 1(f)(3)  
7                   for the calendar year in which such  
8                   taxable year begins, determined by  
9                   substituting ‘the calendar year pre-  
10                  ceding the first calendar year to which  
11                  section 224 applies’ for ‘calendar year  
12                  1992’ in subparagraph (B) thereof.

13                  “(ii) ROUNDING.—If any increase  
14                  under clause (i) is not a multiple of \$50,  
15                  such increase shall be rounded to the near-  
16                  est multiple of \$50.

17                  “(3) YEARLY LIMITATION.—The amount al-  
18                  lowed as a deduction under subsection (a) for any  
19                  taxable year shall not exceed the taxpayer’s earned  
20                  income (as defined in section 32(c)(2)) for such tax-  
21                  able year.

22                  “(c) LIMITATIONS AND SPECIAL RULES RELATING  
23 TO STANDARD DEDUCTION.—For purposes of this sec-  
24 tion—

1           “(1) SPECIAL RULE FOR MARRIED INDIVIDUALS  
2           FILING SEPARATELY.—In the case of a married indi-  
3           vidual who files a separate return for the taxable  
4           year, the deduction allowed under subsection (a)  
5           shall be equal to one-half of the amount which would  
6           otherwise be determined under subsection (a) if such  
7           individual filed a joint return for the taxable year.

8           “(2) DENIAL OF DEDUCTION TO DEPEND-  
9           ENTS.—No deduction shall be allowed under this  
10          section to any individual with respect to whom a de-  
11          duction under section 151 is allowable to another  
12          taxpayer for a taxable year beginning in the cal-  
13          endar year in which such individual’s taxable year  
14          begins.

15          “(3) COORDINATION WITH OTHER HEALTH TAX  
16          INCENTIVES.—

17                 “(A) DENIAL OF DEDUCTION IF HEALTH  
18                 INSURANCE COSTS CREDIT ALLOWED.—No de-  
19                 duction shall be allowed under this section to  
20                 any taxpayer if a credit is allowed to the tax-  
21                 payer under section 35 for the taxable year.

22                 “(B) REDUCTION FOR INSURANCE PUR-  
23                 CHASED WITH MSA OR HSA FUNDS.—The  
24                 amount allowed as a deduction under subsection



1 (a) for the taxable year shall be reduced by the  
2 aggregate amount—

3 “(i) paid during the taxable year from  
4 an Archer MSA to which section  
5 220(d)(2)(B)(ii) (other than subclause (II)  
6 thereof) applies, and

7 “(ii) paid during the taxable year  
8 from a health savings account to which  
9 section 223(d)(2)(C) (other than clause (ii)  
10 thereof) applies.

11 “(4) SPECIAL RULE FOR DIVORCED PARENTS,  
12 ETC.—Notwithstanding subsection (b)(1), an indi-  
13 vidual who is a child may be taken into account on  
14 the return of the parent other than the parent for  
15 whom a deduction with respect to the child is al-  
16 lowed under section 151 for a taxable year beginning  
17 in a calendar year if—

18 “(A) the parent for whom the deduction  
19 under section 151 is allowed for a taxable year  
20 beginning in such calendar year signs a written  
21 declaration (in such manner and form as the  
22 Secretary may by regulations prescribe) that  
23 such parent will not claim the deduction allow-  
24 able under this section with respect to the child

1 for taxable years beginning in such calendar  
2 year, and

3 “(B) the parent for whom the deduction  
4 under section 151 is not allowed attaches such  
5 written declaration to the parent’s return for  
6 the taxable year beginning in such calendar  
7 year.

8 “(d) OTHER DEFINITIONS.—For purposes of this  
9 section—

10 “(1) ELIGIBLE INDIVIDUAL.—

11 “(A) IN GENERAL.—The term ‘eligible in-  
12 dividual’ means, with respect to any month, an  
13 individual who is covered under a qualified  
14 health plan as of the 1st day of such month.

15 “(B) COVERAGE UNDER MEDICARE, MED-  
16 ICAID, SCHIP, TRICARE, AND GRANDFATHERED  
17 EMPLOYER COVERAGE.—The term ‘eligible indi-  
18 vidual’ shall not include any individual who for  
19 any month is—

20 “(i) entitled to benefits under part A  
21 of title XVIII of the Social Security Act or  
22 enrolled under part B of such title,

23 “(ii) enrolled in the program under  
24 title XIX or XXI of such Act (other than  
25 under section 1928 of such Act),

1           “(iii) receiving benefits (other than  
2           under continuation coverage under section  
3           4980B) which constitute medical care from  
4           an employer—

5                   “(I) from whom such individual  
6                   is separated from service at the time  
7                   of receipt of such benefits, and

8                   “(II) after such separation, if  
9                   such benefits began before January 1,  
10                  2015, unless such individual is also  
11                  covered by a qualified health plan as  
12                  of the 1st day of such month, or

13                  “(iv) entitled to receive benefits under  
14                  chapter 55 of title 10, United States Code.

15                  “(C) IDENTIFICATION REQUIREMENTS.—

16                  The term ‘eligible individual’ shall not include  
17                  any individual for any month unless the policy  
18                  number associated with coverage under the  
19                  qualified health plan and the TIN of each eligi-  
20                  ble individual covered under such coverage for  
21                  such month is included on the return for the  
22                  taxable year in which such month occurs.

23                  “(2) QUALIFIED HEALTH PLAN.—

24                   “(A) IN GENERAL.—The term ‘qualified  
25                   health plan’ means a health plan (within the

1 meaning of section 223(c)(2), without regard to  
2 subparagraph (A)(i) thereof) which, under regu-  
3 lations prescribed by the Secretary, meets the  
4 following requirements:

5 “(i) The plan has coverage for inpa-  
6 tient and outpatient care, emergency bene-  
7 fits, and physician care.

8 “(ii) The plan has coverage which  
9 meaningfully limits individual economic ex-  
10 posure to extraordinary medical expenses

11 “(B) EXCLUSION OF CERTAIN PLANS.—  
12 The term ‘qualified health plan’ does not in-  
13 clude—

14 “(i) a health plan if substantially all  
15 of its coverage is coverage described in sec-  
16 tion 223(c)(1)(B),

17 “(ii) any program or benefits referred  
18 to in clause (i), (ii), or (iii) of paragraph  
19 (1)(B), and

20 “(iii) a medicare supplemental policy  
21 (as defined in section 1882 of the Social  
22 Security Act).

23 “(e) REGULATIONS.—The Secretary may prescribe  
24 such regulations as may be necessary to carry out this  
25 section.”.

1 (b) DEDUCTION ALLOWED WHETHER OR NOT INDI-  
 2 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
 3 of section 62 is amended by inserting before the last sen-  
 4 tence at the end the following new paragraph:

5 “(22) STANDARD DEDUCTION FOR HEALTH IN-  
 6 SURANCE.—The deduction allowed by section 224.”.

7 (c) ELECTION TO TAKE HEALTH INSURANCE COSTS  
 8 CREDIT.—Section 35(g) is amended by redesignating the  
 9 paragraph added by section 1899E(a) of the TAA Health  
 10 Coverage Improvement Act of 2009, the paragraph added  
 11 by section 3001(a)(14)(A) of the American Recovery and  
 12 Reinvestment Act of 2009, and the last paragraph thereof  
 13 (relating to regulations) as paragraphs (10), (11), and  
 14 (12), respectively, and by inserting after paragraph (8) the  
 15 following new paragraph:

16 “(9) ELECTION NOT TO CLAIM CREDIT.—This  
 17 section shall not apply to a taxpayer for any taxable  
 18 year if such taxpayer elects to have this section not  
 19 apply for such taxable year.”.

20 (d) CLERICAL AMENDMENT.—The table of sections  
 21 for part VII of subchapter B of chapter 1 is amended by  
 22 striking the item relating to section 224 and adding at  
 23 the end the following new items:

“Sec. 224. Standard deduction for health insurance.

“Sec. 225. Cross reference.”.

1 (e) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2014.

4 **SEC. 202. CHANGES TO EXISTING TAX PREFERENCES FOR**  
5 **MEDICAL COVERAGE AND COSTS FOR INDIVIDUALS ELIGIBLE FOR STANDARD DEDUC-**  
6 **TION FOR HEALTH INSURANCE.**

8 (a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER  
9 TO ACCIDENT AND HEALTH PLANS.—

10 (1) IN GENERAL.—Section 106 is amended by  
11 adding at the end the following new subsection:

12 “(g) SUBSECTIONS (a) AND (c) APPLY ONLY TO IN-  
13 DIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP,  
14 TRICARE, OR GRANDFATHERED EMPLOYER PLANS.—

15 “(1) IN GENERAL.—Except as provided in para-  
16 graph (2), subsections (a) and (c) shall not apply for  
17 any taxable year with respect to which a deduction  
18 under section 224 is allowable.

19 “(2) EXCEPTION FOR INDIVIDUALS COVERED  
20 BY MEDICARE, MEDICAID, SCHIP, OR GRAND-  
21 FATHERED EMPLOYER PLANS.—Paragraph (1) shall  
22 not apply to an individual for any taxable year if  
23 such individual is not an eligible individual (as de-  
24 fined in section 224(d)(1)) for any month during

1 such taxable year by reason of coverage described in  
2 section 224(d)(1)(B).”.

3 (2) CONFORMING AMENDMENTS.—

4 (A) Section 106(b)(1) is amended—

5 (i) by inserting “gross income does  
6 not include” before “amounts contrib-  
7 uted”, and

8 (ii) by striking “shall be treated as  
9 employer-provided coverage for medical ex-  
10 penses under an accident or health plan”.

11 (B) Section 106(d)(1) is amended—

12 (i) by inserting “gross income does  
13 not include” before “amounts contrib-  
14 uted”, and

15 (ii) by striking “shall be treated as  
16 employer-provided coverage for medical ex-  
17 penses under an accident or health plan”.

18 (b) TERMINATION OF DEDUCTION FOR HEALTH IN-  
19 SURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

20 Subsection (l) of section 162 is amended by adding at the  
21 end the following new paragraph:

22 “(6) TERMINATION.—This subsection shall not  
23 apply to taxable years with respect to which a deduc-  
24 tion under section 224 is allowable.”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2014.

4 **SEC. 203. EXCLUSION OF STANDARD DEDUCTION FOR**  
5 **HEALTH INSURANCE FROM EMPLOYMENT**  
6 **TAXES.**

7 (a) IN GENERAL.—Chapter 25 is amended by adding  
8 at the end the following new section:

9 **“SEC. 3511. EXCLUSION OF STANDARD DEDUCTION FROM**  
10 **EMPLOYMENT TAXES.**

11 “(a) IN GENERAL.—For purposes of chapters 21, 22,  
12 and 23, each of the following amounts for any period (de-  
13 termined without regard to this section) shall be reduced  
14 by the portion of the standard deduction for health insur-  
15 ance (as defined in section 224) allocable to the period:

16 “(1) The amount of wages determined under  
17 section 3121(a).

18 “(2) The amount of compensation determined  
19 under section 3231(e).

20 “(3) The amount of wages determined under  
21 section 3306(b).

22 “(b) DETERMINATION OF STANDARD DEDUCTION  
23 ALLOCABLE TO A PERIOD.—For purposes of subsection  
24 (a)—



1           “(1) IN GENERAL.—The determination of the  
2           portion of the standard deduction for health insur-  
3           ance allocable to a period shall be made on the basis  
4           of a qualified certificate of eligible coverage fur-  
5           nished by the employee to the employer.

6           “(2) QUALIFIED CERTIFICATE OF ELIGIBLE  
7           COVERAGES.—The term ‘qualified certificate of eligi-  
8           ble coverage’ means a statement of eligibility for the  
9           deduction allowable under section 224 which con-  
10          tains such information, is in such form, and is pro-  
11          vided at such times, as the Secretary may prescribe.

12          “(3) ONLY 1 CERTIFICATE IN EFFECT AT A  
13          TIME.—Except as provided by the Secretary, an em-  
14          ployee may have only 1 qualified certificate of eligi-  
15          ble coverage in effect for any period.

16          “(4) ELECTION.—An employee may elect not to  
17          have this section apply for any period for purposes  
18          of chapter 21 or 22.

19          “(c) RECONCILIATION OF ERRONEOUS PAYMENTS TO  
20          BE MADE AT EMPLOYEE LEVEL.—

21                 “(1) IN GENERAL.—If the application of this  
22                 subsection results in an incorrect amount being  
23                 treated as wages or compensation for purposes of  
24                 chapter 21, 22, or 23, whichever is applicable, with

1 respect to any employee for 1 or more periods end-  
2 ing within a taxable year of the employee—

3 “(A) in the case of an aggregate overpay-  
4 ment of the taxes imposed by any such chapter  
5 for all such periods, there shall be allowed as a  
6 credit against the tax imposed by chapter 1 for  
7 such taxable year on such employee an amount  
8 equal to the amount of such overpayment, and

9 “(B) in the case of an aggregate under-  
10 payment of the taxes imposed by any such  
11 chapter for all such periods, the employee shall  
12 be liable for payment of the entire amount of  
13 such underpayment.

14 “(2) CREDITS TREATED AS REFUNDABLE.—For  
15 purposes of this title, any credit determined under  
16 paragraph (1)(A) or subsection (d)(2) shall be treat-  
17 ed as if it were a credit allowed under subpart C of  
18 part IV of subchapter A of chapter 1.

19 “(3) RULES FOR REPORTING AND COLLECTION  
20 OF TAX.—Any tax required to be paid by an em-  
21 ployee under paragraph (1)(B) shall be included  
22 with the employee’s return of Federal income tax for  
23 the taxable year.

1           “(4) SECRETARIAL AUTHORITY.—The Secretary  
2           shall prescribe such rules as may be necessary to  
3           carry out the provisions of this subsection.”.

4           (b) SELF-EMPLOYMENT INCOME.—Section 1402 is  
5           amended by adding at the end the following:

6           “(m) STANDARD DEDUCTION FOR HEALTH INSUR-  
7           ANCE.—For purposes of this chapter—

8           “(1) IN GENERAL.—The self-employment in-  
9           come of a taxpayer for any period (determined with-  
10          out regard to this subsection) shall be reduced by  
11          the excess (if any) of—

12                   “(A) the portion of the standard deduction  
13                   for health insurance (as defined in section 224)  
14                   allocable to the period, over

15                   “(B) the amount of any reduction in wages  
16                   or compensation for such period under section  
17                   3511.

18          “(2) DETERMINATION OF STANDARD DEDUC-  
19          TION ALLOCABLE TO A PERIOD.—For purposes of  
20          paragraph (1), the portion of the standard deduction  
21          allocable to any period shall be determined in a man-  
22          ner similar to the manner under section 3511.”.

23          (c) CONFORMING AMENDMENTS.—

1           (1) Section 3121(a)(2) is amended by inserting  
2           “which is excludable from gross income under sec-  
3           tion 105 or 106” after “such payment”).

4           (2) Subsection (a) of section 209 of the Social  
5           Security Act (42 U.S.C. 409) is amended by striking  
6           “or” at the end of paragraph (18), by striking the  
7           period at the end of paragraph (19) and inserting “;  
8           or”, and by inserting after paragraph (19) the fol-  
9           lowing new paragraph:

10           “(20) any amount excluded from wages under  
11           section 3511(a) of the Internal Revenue Code of  
12           1986 (relating to exclusion of standard deduction  
13           from employment taxes).”.

14           (3) Section 1324(b)(2) of title 31, United  
15           States Code, is amended by inserting “, or the credit  
16           under section 3511(c)(2) of such Code” before the  
17           period at the end.

18           (4) Section 209(k)(2) of the Social Security Act  
19           (42 U.S.C. 409(k)(2)) is amended by redesignating  
20           subparagraphs (C) and (D) as subparagraphs (D)  
21           and (E), respectively, and by inserting after sub-  
22           paragraph (B) the following new subparagraph:

23           “(C) by disregarding the exclusion from  
24           wages in subsection (a)(20),”.

1           (5) The table of sections for chapter 25 is  
2           amended by adding at the end the following new  
3           item:

“Sec. 3511. Exclusion of standard deduction from employment taxes.”.

4           (d) **EFFECTIVE DATES.**—

5           (1) **IN GENERAL.**—Except as provided in para-  
6           graph (2), the amendments made by this section  
7           shall apply to remuneration paid or accrued for peri-  
8           ods on or after December 31, 2014.

9           (2) **RECONCILIATION AND SELF-EMPLOYED.**—  
10          Sections 3511(c) and (d)(2) of the Internal Revenue  
11          Code of 1986 (as added by subsection (a)), and the  
12          amendments made by subsection (b), shall apply to  
13          taxable years beginning after December 31, 2014.

14 **SEC. 204. INFORMATION REPORTING.**

15          (a) **HEALTH PLAN PROVIDERS.**—Subpart B of part  
16          III of subchapter A of chapter 61 is amended by adding  
17          at the end the following new section:

18 **“SEC. 6050X. COVERAGE UNDER QUALIFIED HEALTH PLAN.**

19          “(a) **IN GENERAL.**—Every person providing coverage  
20          under a qualified health plan (as defined in section  
21          224(d)(2)) during a calendar year shall, on or before Jan-  
22          uary 31 of the succeeding year, make a return described  
23          in subsection (b) with respect to each individual who is  
24          covered by such person under a qualified health plan for  
25          any month during the calendar year.

1       “(b) RETURN.—A return is described in this sub-  
2 section if such return—

3               “(1) is in such form as the Secretary pre-  
4 scribes, and

5               “(2) contains—

6                       “(A) the name of the person providing cov-  
7 erage under the qualified health plan,

8                       “(B) the name, address, and TIN of the  
9 individual covered by the plan,

10                      “(C) if such individual is the owner of the  
11 policy under which such plan is provided, the  
12 name, address, and TIN of each other indi-  
13 vidual covered by such policy and the relation-  
14 ship of each such individual to such owner, and

15                      “(D) the specific months of the year for  
16 which each individual referred to in subpara-  
17 graph (B) is, as of the first day of each such  
18 month, covered by such plan.

19       “(c) STATEMENT TO BE FURNISHED WITH RE-  
20 SPECT TO WHOM INFORMATION IS REQUIRED.—Every  
21 person required to make a return under subsection (a)  
22 shall furnish to each individual whose name is required  
23 to be set forth in such return under subsection (b)(2)(A)  
24 a written statement showing—

1           “(1) the name, address, and phone number of  
2           the information contact of the person required to  
3           make such return, and

4           “(2) the information described in subsection  
5           (b)(2).

6           The written statement required under the preceding sen-  
7           tence shall be furnished on or before January 31 of the  
8           year following the calendar year for which the return  
9           under subsection (a) was required to be made.”.

10          (b) EMPLOYERS.—Subsection (a) of section 6051 is  
11          amended by striking “and” at the end of paragraph (12),  
12          by striking the period at the end of paragraph (13) and  
13          inserting “, and”, and by inserting after paragraph (13)  
14          the following new paragraph:

15                 “(14) the value (determined under section  
16                 4980B(f)(4)) of employer-provided coverage for each  
17                 month under an accident or health plan and the cat-  
18                 egory of such coverage for purposes of section  
19                 6116.”.

20          (c) APPLICATION TO RETIREES.—Subsection (a) of  
21          section 6051 is amended by adding at the end the fol-  
22          lowing: “In the case of a retiree, this section shall (to the  
23          extent established by the Secretary by regulation) apply  
24          only with respect to paragraph (14).”.

25          (d) ASSESSABLE PENALTIES.—

1           (1) Subparagraph (B) of section 6724(d)(1) is  
2           amended by striking “or” at the end of clause  
3           (xxiv), by striking “and” at the end of clause (xxv)  
4           and inserting “or”, and by adding at the end the fol-  
5           lowing new clause:

6                         “(xxvi) section 6050X (relating to re-  
7                         turns relating to payments for qualified  
8                         health insurance), and”.

9           (2) Paragraph (2) of section 6724(d) is amend-  
10          ed by striking “or” at the end of subparagraph  
11          (GG), by striking the period at the end of subpara-  
12          graph (HH) and inserting “, or” and by adding at  
13          the end the following new subparagraph:

14                       “(II) section 6050X(d) (relating to returns  
15                       relating to payments for qualified health insur-  
16                       ance).”.

17          (e) CLERICAL AMENDMENT.—The table of sections  
18          for such subpart B is amended by adding at the end the  
19          following new item:

          “Sec. 6050X. Coverage under qualified health plan.”.

20          (f) EFFECTIVE DATE.—The amendments made by  
21          this section shall apply to years beginning after December  
22          31, 2014.



1 **SEC. 205. ELECTION TO DISREGARD INCLUSION OF CON-**  
 2 **TRIBUTIONS BY EMPLOYER TO ACCIDENT OR**  
 3 **HEALTH PLAN.**

4 (a) IN GENERAL.—Subparagraph (B) of section  
 5 32(c)(2) is amended by striking “and” at the end of clause  
 6 (v), by striking the period at the end of clause (vi) and  
 7 inserting “, and”, and by adding at the end the following  
 8 new clause:

9 “(vii) a taxpayer may elect to exclude  
 10 from earned income amounts that would  
 11 have been excluded from gross income  
 12 under section 106 but for subsection (g)  
 13 thereof.”.

14 (b) EFFECTIVE DATE.—The amendments made by  
 15 subsection (a) shall apply to taxable years beginning De-  
 16 cember 31, 2014.

17 **Subtitle B—Enhancement of Health**  
 18 **Savings Accounts**

19 **SEC. 221. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**  
 20 **TRIBUTIONS TO THE SAME HSA ACCOUNT.**

21 (a) IN GENERAL.—Paragraph (3) of section 223(b)  
 22 is amended by adding at the end the following new sub-  
 23 paragraph:

24 “(C) SPECIAL RULE WHERE BOTH  
 25 SPOUSES ARE ELIGIBLE INDIVIDUALS WITH 1  
 26 ACCOUNT.—If—

1                   “(i) an individual and the individual’s  
2                   spouse have both attained age 55 before  
3                   the close of the taxable year, and

4                   “(ii) the spouse is not an account ben-  
5                   eficiary of a health savings account as of  
6                   the close of such year,

7                   the additional contribution amount shall be 200  
8                   percent of the amount otherwise determined  
9                   under subparagraph (B).”.

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 **SEC. 222. PROVISIONS RELATING TO MEDICARE.**

14           (a) INDIVIDUALS OVER AGE 65 ONLY ENROLLED IN  
15 MEDICARE PART A.—Paragraph (7) of section 223(b) is  
16 amended by adding at the end the following: “This para-  
17 graph shall not apply to any individual during any period  
18 for which the individual’s only entitlement to such benefits  
19 is an entitlement to hospital insurance benefits under part  
20 A of title XVIII of such Act pursuant to an enrollment  
21 for such hospital insurance benefits under section  
22 226(a)(1) of such Act.”.

23           (b) MEDICARE BENEFICIARIES PARTICIPATING IN  
24 MEDICARE ADVANTAGE MSA MAY CONTRIBUTE THEIR  
25 OWN MONEY TO THEIR MSA.—

1           (1) IN GENERAL.—Subsection (b) of section  
2           138 is amended by striking paragraph (2) and by re-  
3           designating paragraphs (3) and (4) as paragraphs  
4           (2) and (3), respectively.

5           (2) CONFORMING AMENDMENT.—Paragraph (4)  
6           of section 138(c) is amended by striking “and para-  
7           graph (2)”.

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

11 **SEC. 223. INDIVIDUALS ELIGIBLE FOR VETERANS BENE-**  
12                           **FITS FOR A SERVICE-CONNECTED DIS-**  
13                           **ABILITY.**

14          (a) IN GENERAL.—Paragraph (1) of section 223(c)  
15          is amended by adding at the end the following new sub-  
16          paragraph:

17                           “(C) SPECIAL RULE FOR INDIVIDUALS ELI-  
18                           GIBLE FOR CERTAIN VETERANS BENEFITS.—  
19                           For purposes of subparagraph (A)(ii), an indi-  
20                           vidual shall not be treated as covered under a  
21                           health plan described in such subparagraph  
22                           merely because the individual receives periodic  
23                           hospital care or medical services for a service-  
24                           connected disability under any law administered  
25                           by the Secretary of Veterans Affairs but only if

1 the individual is not eligible to receive such care  
2 or services for any condition other than a serv-  
3 ice-connected disability.”.

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

7 **SEC. 224. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH**  
8 **SERVICE ASSISTANCE.**

9 (a) IN GENERAL.—Paragraph (1) of section 223(c),  
10 as amended by this Act, is amended by adding at the end  
11 the following new subparagraph:

12 “(D) SPECIAL RULE FOR INDIVIDUALS EL-  
13 IGIBLE FOR ASSISTANCE UNDER INDIAN  
14 HEALTH SERVICE PROGRAMS.—For purposes of  
15 subparagraph (A)(ii), an individual shall not be  
16 treated as covered under a health plan de-  
17 scribed in such subparagraph merely because  
18 the individual receives hospital care or medical  
19 services under a medical care program of the  
20 Indian Health Service or of a tribal organiza-  
21 tion.”.

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

1 **SEC. 225. INDIVIDUALS ELIGIBLE FOR TRICARE COVERAGE.**

2 (a) IN GENERAL.—Paragraph (1) of section 223(c),  
3 as amended by this Act, is amended by adding at the end  
4 the following new subparagraph:

5 “(E) SPECIAL RULE FOR INDIVIDUALS EL-  
6 IGIBLE FOR ASSISTANCE UNDER TRICARE.—For  
7 purposes of subparagraph (A)(ii), an individual  
8 shall not be treated as covered under a health  
9 plan described in such subparagraph merely be-  
10 cause the individual is eligible to receive hos-  
11 pital care, medical services, or prescription  
12 drugs under TRICARE Extra or TRICARE  
13 Standard and such individual is not enrolled in  
14 TRICARE Prime.”.

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

18 **SEC. 226. FSA AND HRA INTERACTION WITH HSAS.**

19 (a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA  
20 PARTICIPANTS.—Subparagraph (B) of section 223(c)(1)  
21 is amended—

22 (1) by striking “and” at the end of clause (ii),

23 (2) by striking the period at the end of clause

24 (iii) and inserting “, and”, and

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

1           “(iv) coverage under a health flexible  
2           spending arrangement or a health reim-  
3           bursement arrangement in the plan year a  
4           qualified HSA distribution as described in  
5           section 106(e) is made on behalf of the in-  
6           dividual if after the qualified HSA dis-  
7           tribution is made and for the remaining  
8           duration of the plan year, the coverage  
9           provided under the health flexible spending  
10          arrangement or health reimbursement ar-  
11          rangement is converted to—

12                   “(I) coverage that does not pay  
13                   or reimburse any medical expense in-  
14                   curred before the minimum annual de-  
15                   ductible under paragraph (2)(A)(i)  
16                   (prorated for the period occurring  
17                   after the qualified HSA distribution is  
18                   made) is satisfied,

19                   “(II) coverage that, after the  
20                   qualified HSA distribution is made,  
21                   does not pay or reimburse any med-  
22                   ical expense incurred after the quali-  
23                   fied HSA distribution is made other  
24                   than preventive care as defined in  
25                   paragraph (2)(C),

1 “(III) coverage that, after the  
2 qualified HSA distribution is made,  
3 pays or reimburses benefits for cov-  
4 erage described in clause (ii) (but not  
5 through insurance or for long-term  
6 care services),

7 “(IV) coverage that, after the  
8 qualified HSA distribution is made,  
9 pays or reimburses benefits for per-  
10 mitted insurance or coverage de-  
11 scribed in clause (ii) (but not for long-  
12 term care services),

13 “(V) coverage that, after the  
14 qualified HSA distribution is made,  
15 pays or reimburses only those medical  
16 expenses incurred after an individual’s  
17 retirement (and no expenses incurred  
18 before retirement), or

19 “(VI) coverage that, after the  
20 qualified HSA distribution is made, is  
21 suspended, pursuant to an election  
22 made on or before the date the indi-  
23 vidual elects a qualified HSA distribu-  
24 tion or, if later, on the date of the in-  
25 dividual enrolls in a high deductible

1 health plan, that does not pay or re-  
2 imburse, at any time, any medical ex-  
3 pense incurred during the suspension  
4 period except as defined in the pre-  
5 ceding subclauses of this clause.”.

6 (b) QUALIFIED HSA DISTRIBUTION SHALL NOT AF-  
7 FECT FLEXIBLE SPENDING ARRANGEMENT.—Paragraph  
8 (1) of section 106(e) is amended to read as follows:

9 “(1) IN GENERAL.—A plan shall not fail to be  
10 treated as a health flexible spending arrangement  
11 under this section, section 105, or section 125, or as  
12 a health reimbursement arrangement under this sec-  
13 tion or section 105, merely because such plan pro-  
14 vides for a qualified HSA distribution.”.

15 (c) FSA BALANCES AT YEAR END SHALL NOT FOR-  
16 FEIT.—Paragraph (2) of section 125(d) is amended by  
17 adding at the end the following new subparagraph:

18 “(E) EXCEPTION FOR QUALIFIED HSA DIS-  
19 TRIBUTIONS.—Subparagraph (A) shall not  
20 apply to the extent that there is an amount re-  
21 maining in a health flexible spending account at  
22 the end of a plan year that an individual elects  
23 to contribute to a health savings account pursu-  
24 ant to a qualified HSA distribution (as defined  
25 in section 106(e)(2)).”.



1 (d) SIMPLIFICATION OF LIMITATIONS ON FSA AND  
 2 HRA ROLLOVERS.—Paragraph (2) of section 106(e) is  
 3 amended to read as follows:

4 “(2) QUALIFIED HSA DISTRIBUTION.—

5 “(A) IN GENERAL.—The term ‘qualified  
 6 HSA distribution’ means a distribution from a  
 7 health flexible spending arrangement or health  
 8 reimbursement arrangement to the extent that  
 9 such distribution does not exceed the lesser  
 10 of—

11 “(i) the balance in such arrangement  
 12 as of the date of such distribution, or

13 “(ii) the amount determined under  
 14 subparagraph (B).

15 Such term shall not include more than 1 dis-  
 16 tribution with respect to any arrangement.

17 “(B) DOLLAR LIMITATIONS.—

18 “(i) DISTRIBUTIONS FROM A HEALTH  
 19 FLEXIBLE SPENDING ARRANGEMENT.—A  
 20 qualified HSA distribution from a health  
 21 flexible spending arrangement shall not ex-  
 22 ceed the applicable amount.

23 “(ii) DISTRIBUTIONS FROM A HEALTH  
 24 REIMBURSEMENT ARRANGEMENT.—A  
 25 qualified HSA distribution from a health

1 reimbursement arrangement shall not ex-  
2 ceed—

3 “(I) the applicable amount di-  
4 vided by 12, multiplied by

5 “(II) the number of months dur-  
6 ing which the individual is a partici-  
7 pant in the health reimbursement ar-  
8 rangement.

9 “(iii) APPLICABLE AMOUNT.—For  
10 purposes of this subparagraph, the applica-  
11 ble amount is—

12 “(I) \$2,250 in the case of an eli-  
13 gible individual who has self-only cov-  
14 erage under a high deductible health  
15 plan at the time of such distribution,  
16 and

17 “(II) \$4,500 in the case of an eli-  
18 gible individual who has family cov-  
19 erage under a high deductible health  
20 plan at the time of such distribu-  
21 tion.”.

22 (e) ELIMINATION OF ADDITIONAL TAX FOR FAILURE  
23 TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COV-  
24 ERAGE.—Subsection (e) of section 106 is amended—

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

4           (2) by striking subparagraph (A) of paragraph  
5 (3), as so redesignated, and redesignating subpara-  
6 graphs (B) and (C) of such paragraph as subpara-  
7 graphs (A) and (B) thereof, respectively.

8           (f) LIMITED PURPOSE FSAS AND HRAS.—Sub-  
9 section (e) of section 106, as amended by this section, is  
10 amended by adding at the end the following new para-  
11 graph:

12           “(5) LIMITED PURPOSE FSAS AND HRAS.—A  
13 plan shall not fail to be a health flexible spending  
14 arrangement or health reimbursement arrangement  
15 under this section or section 105 merely because the  
16 plan converts coverage for individuals who enroll in  
17 a high deductible health plan described in section  
18 223(c)(2) to coverage described in section  
19 223(c)(1)(B)(iv). Coverage for such individuals may  
20 be converted as of the date of enrollment in the high  
21 deductible health plan, without regard to the period  
22 of coverage under the health flexible spending ar-  
23 rangement or health reimbursement arrangement,  
24 and without requiring any change in coverage to in-

1 individuals who do not enroll in a high deductible  
2 health plan.”.

3 (g) DISTRIBUTION AMOUNTS ADJUSTED FOR COST-  
4 OF-LIVING.—Subsection (e) of section 106, as amended  
5 by this section, is amended by adding at the end the fol-  
6 lowing new paragraph:

7 “(6) COST-OF-LIVING ADJUSTMENT.—

8 “(A) IN GENERAL.—In the case of any  
9 taxable year beginning in a calendar year after  
10 2013, each of the dollar amounts in paragraph  
11 (2)(B)(iii) shall be increased by an amount  
12 equal to such dollar amount, multiplied by the  
13 cost-of-living adjustment determined under sec-  
14 tion 1(f)(3) for the calendar year in which such  
15 taxable year begins by substituting ‘calendar  
16 year 2012’ for ‘calendar year 1992’ in subpara-  
17 graph (B) thereof.

18 “(B) ROUNDING.—If any increase under  
19 paragraph (1) is not a multiple of \$50, such in-  
20 crease shall be rounded to the nearest multiple  
21 of \$50.”.

22 (h) DISCLAIMER OF DISQUALIFYING COVERAGE.—  
23 Subparagraph (B) of section 223(c)(1), as amended by  
24 this section, is amended—

25 (1) by striking “and” at the end of clause (iii),

1           (2) by striking the period at the end of clause  
2           (iv) and inserting “, and”, and

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

5                       “(v) any coverage (including prospec-  
6                       tive coverage) under a health plan that is  
7                       not a high deductible health plan which is  
8                       disclaimed in writing, at the time of the  
9                       creation or organization of the health sav-  
10                      ings account, including by execution of a  
11                      trust described in subsection (d)(1)  
12                      through a governing instrument that in-  
13                      cludes such a disclaimer, or by acceptance  
14                      of an amendment to such a trust that in-  
15                      cludes such a disclaimer.”.

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

19 **SEC. 227. PURCHASE OF HEALTH INSURANCE FROM HSA**  
20 **ACCOUNT.**

21           (a) IN GENERAL.—Paragraph (2) of section 223(d)  
22 is amended to read as follows:

23                       “(2) QUALIFIED MEDICAL EXPENSES.—

24                               “(A) IN GENERAL.—The term ‘qualified  
25                               medical expenses’ means, with respect to an ac-

1 count beneficiary, amounts paid by such bene-  
2 ficiary for medical care (as defined in section  
3 213(d)) for any individual covered by a high de-  
4 ductible health plan of the account beneficiary,  
5 but only to the extent such amounts are not  
6 compensated for by insurance or otherwise.

7 “(B) HEALTH INSURANCE MAY NOT BE  
8 PURCHASED FROM ACCOUNT.—Except as pro-  
9 vided in subparagraph (C), subparagraph (A)  
10 shall not apply to any payment for insurance.

11 “(C) EXCEPTIONS.—Subparagraph (B)  
12 shall not apply to any expense for coverage  
13 under—

14 “(i) a health plan during any period  
15 of continuation coverage required under  
16 any Federal law,

17 “(ii) a qualified long-term care insur-  
18 ance contract (as defined in section  
19 7702B(b)),

20 “(iii) a health plan during any period  
21 in which the individual is receiving unem-  
22 ployment compensation under any Federal  
23 or State law,

24 “(iv) a high deductible health plan, or

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

5           (b) EFFECTIVE DATE.—The amendment made by  
6 this section shall apply with respect to insurance pur-  
7 chased after the date of the enactment of this Act in tax-  
8 able years beginning after such date.

9   **SEC. 228. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**  
10                   **INCURRED BEFORE ESTABLISHMENT OF AC-**  
11                   **COUNT.**

12           (a) IN GENERAL.—Paragraph (2) of section 223(d),  
13 as amended by this Act, is amended by adding at the end  
14 the following new subparagraph:

15                   “(D) CERTAIN MEDICAL EXPENSES IN-  
16                   CURRED BEFORE ESTABLISHMENT OF ACCOUNT  
17                   TREATED AS QUALIFIED.—An expense shall not  
18                   fail to be treated as a qualified medical expense  
19                   solely because such expense was incurred before  
20                   the establishment of the health savings account  
21                   if such expense was incurred—

22                           “(i) during either—

23                                   “(I) the taxable year in which the  
24                                   health savings account was estab-  
25                                   lished, or

1                   “(II) the preceding taxable year  
2                   in the case of a health savings ac-  
3                   count established after the taxable  
4                   year in which such expense was in-  
5                   curred but before the time prescribed  
6                   by law for filing the return for such  
7                   taxable year (not including extensions  
8                   thereof), and

9                   “(ii) for medical care of an individual  
10                  during a period that such individual was  
11                  covered by a high deductible health plan  
12                  and met the requirements of subsection  
13                  (c)(1)(A)(ii) (after application of sub-  
14                  section (c)(1)(B)).”.

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

18 **SEC. 229. PREVENTIVE CARE PRESCRIPTION DRUG CLARI-**  
19 **FICATION.**

20           (a) CLARIFY USE OF DRUGS IN PREVENTIVE  
21 CARE.—Subparagraph (C) of section 223(c)(2) is amend-  
22 ed by adding at the end the following: “Preventive care  
23 shall include prescription and over-the-counter drugs and  
24 medicines which have the primary purpose of preventing



1 the onset of, further deterioration from, or complications  
2 associated with chronic conditions, illnesses, or diseases.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 this section shall apply to taxable years beginning after  
5 December 31, 2003.

6 **SEC. 230. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**  
7 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**  
8 **MENT FUNDS.**

9 (a) IN GENERAL.—Section 522 of title 11, United  
10 States Code, is amended by adding at the end the fol-  
11 lowing new subsection:

12 “(r) TREATMENT OF HEALTH SAVINGS AC-  
13 COUNTS.—For purposes of this section, any health savings  
14 account (as described in section 223 of the Internal Rev-  
15 enue Code of 1986) shall be treated in the same manner  
16 as an individual retirement account described in section  
17 408 of such Code.”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 this section shall apply to cases commencing under title  
20 11, United States Code, after the date of the enactment  
21 of this Act.

1 **SEC. 231. ADMINISTRATIVE ERROR CORRECTION BEFORE**  
2 **DUE DATE OF RETURN.**

3 (a) IN GENERAL.—Paragraph (4) of section 223(f)  
4 is amended by adding at the end the following new sub-  
5 paragraph:

6 “(D) EXCEPTION FOR ADMINISTRATIVE  
7 ERRORS CORRECTED BEFORE DUE DATE OF RE-  
8 TURN.—Subparagraph (A) shall not apply if  
9 any payment or distribution is made to correct  
10 an administrative, clerical or payroll contribu-  
11 tion error and if—

12 “(i) such distribution is received by  
13 the individual on or before the last day  
14 prescribed by law (including extensions of  
15 time) for filing such individual’s return for  
16 such taxable year, and

17 “(ii) such distribution is accompanied  
18 by the amount of net income attributable  
19 to such contribution.

20 Any net income described in clause (ii) shall be  
21 included in the gross income of the individual  
22 for the taxable year in which it is received.”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 this section shall take effect on the date of the enactment  
25 of this Act.

1 **SEC. 232. REAUTHORIZATION OF MEDICAID HEALTH OP-**  
2 **PORTUNITY ACCOUNTS.**

3 (a) IN GENERAL.—Section 1938 of the Social Secu-  
4 rity Act (42 U.S.C. 1396u–8) is amended—

5 (1) in subsection (a)—

6 (A) by striking paragraph (2) and insert-  
7 ing the following:

8 “(2) INITIAL DEMONSTRATION.—The dem-  
9 onstration program under this section shall begin on  
10 January 1, 2007. The Secretary shall approve States  
11 to conduct demonstration programs under this sec-  
12 tion for a 5-year period, with each State demonstra-  
13 tion program covering one or more geographic areas  
14 specified by the State. With respect to a State, after  
15 the initial 5-year period of any demonstration pro-  
16 gram conducted under this section by the State, un-  
17 less the Secretary finds, taking into account cost-ef-  
18 fectiveness and quality of care, that the State dem-  
19 onstration program has been unsuccessful, the dem-  
20 onstration program may be extended or made per-  
21 manent in the State.”; and

22 (B) in paragraph (3), in the matter pre-  
23 ceding subparagraph (A)—

24 (i) by striking “not”; and

25 (ii) by striking “unless” and inserting  
26 “if”;

1 (2) in subsection (b)—

2 (A) in paragraph (3), by inserting “clause  
3 (i) through (vii), (viii) (without regard to the  
4 amendment made by section 2004(c)(2) of Pub-  
5 lic Law 111–148), (x), or (xi) of” after “de-  
6 scribed in”; and

7 (B) by striking paragraphs (4), (5), and  
8 (6);

9 (3) in subsection (c)—

10 (A) by striking paragraphs (3) and (4);

11 (B) by redesignating paragraphs (5)  
12 through (8) as paragraphs (3) through (6), re-  
13 spectively; and

14 (C) in paragraph (4) (as redesignated by  
15 subparagraph (B)), by striking “Subject to sub-  
16 paragraphs (D) and (E)” and inserting “Sub-  
17 ject to subparagraph (D)”; and

18 (4) in subsection (d)—

19 (A) in paragraph (2), by striking subpara-  
20 graph (E); and

21 (B) in paragraph (3)—

22 (i) in subparagraph (A)(ii), by strik-  
23 ing “Subject to subparagraph (B)(ii), in”  
24 and inserting “In”; and

1 (ii) by striking subparagraph (B) and  
2 inserting the following:

3 “(B) MAINTENANCE OF HEALTH OPPOR-  
4 TUNITY ACCOUNT AFTER BECOMING INELI-  
5 GIBLE FOR PUBLIC BENEFIT.—Notwithstanding  
6 any other provision of law, if an account holder  
7 of a health opportunity account becomes ineli-  
8 gible for benefits under this title because of an  
9 increase in income or assets—

10 “(i) no additional contribution shall be  
11 made into the account under paragraph  
12 (2)(A)(i); and

13 “(ii) the account shall remain avail-  
14 able to the account holder for 3 years after  
15 the date on which the individual becomes  
16 ineligible for such benefits for withdrawals  
17 under the same terms and conditions as if  
18 the account holder remained eligible for  
19 such benefits, and such withdrawals shall  
20 be treated as medical assistance in accord-  
21 ance with subsection (c)(4).”.

22 (b) CONFORMING AMENDMENT.—Section 613 of  
23 Public Law 111–3 is repealed.

1 **SEC. 233. MEMBERS OF HEALTH CARE SHARING MIN-**  
2 **ISTRIES ELIGIBLE TO ESTABLISH HEALTH**  
3 **SAVINGS ACCOUNTS.**

4 (a) IN GENERAL.—Section 223 is amended by adding  
5 at the end the following new subsection:

6 “(i) APPLICATION TO HEALTH CARE SHARING MIN-  
7 ISTRIES.—For purposes of this section, membership in a  
8 health care sharing ministry (as defined in section  
9 5000A(d)(2)(B)(ii)) shall be treated as coverage under a  
10 high deductible health plan.”.

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

14 **SEC. 234. HIGH DEDUCTIBLE HEALTH PLANS RENAMED**  
15 **HSA QUALIFIED PLANS.**

16 (a) IN GENERAL.—Section 223, as amended by this  
17 subtitle, is amended by striking “high deductible health  
18 plan” each place it appears and inserting “HSA qualified  
19 health plan”.

20 (b) CONFORMING AMENDMENTS.—

21 (1) Section 106(e), as amended by this subtitle,  
22 is amended by striking “high deductible health plan”  
23 each place it appears and inserting “HSA qualified  
24 health plan”.

25 (2) The heading for paragraph (2) of section  
26 223(c) is amended by striking “HIGH DEDUCTIBLE

1 HEALTH PLAN” and inserting “HSA QUALIFIED  
2 HEALTH PLAN”.

3 (3) Section 408(d)(9) is amended—

4 (A) by striking “high deductible health  
5 plan” each place it appears in subparagraph  
6 (C) and inserting “HSA qualified health plan”,  
7 and

8 (B) by striking “HIGH DEDUCTIBLE  
9 HEALTH PLAN” in the heading of subparagraph  
10 (D) and inserting “HSA QUALIFIED HEALTH  
11 PLAN”.

12 **SEC. 235. TREATMENT OF DIRECT PRIMARY CARE SERVICE**  
13 **ARRANGEMENTS.**

14 (a) IN GENERAL.—Section 223(c) is amended by  
15 adding at the end the following new paragraph:

16 “(6) TREATMENT OF DIRECT PRIMARY CARE  
17 SERVICE ARRANGEMENTS.—An arrangement under  
18 which an individual is provided coverage restricted to  
19 primary care services in exchange for a fixed peri-  
20 odic fee—

21 “(A) shall not be treated as a health plan  
22 for purposes of paragraph (1)(A)(ii), and

23 “(B) shall not be treated as insurance for  
24 purposes of subsection (d)(2)(B).”.

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

4 **SEC. 236. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL**  
5 **FITNESS PROGRAMS TREATED AS MEDICAL**  
6 **CARE.**

7 (a) IN GENERAL.—Subsection (d) of section 213 is  
8 amended by adding at the end the following new para-  
9 graph:

10 “(12) EXERCISE EQUIPMENT AND PHYSICAL  
11 FITNESS PROGRAMS.—

12 “(A) IN GENERAL.—The term ‘medical  
13 care’ shall include amounts paid—

14 “(i) to purchase or use equipment  
15 used in a program (including a self-di-  
16 rected program) of physical exercise,

17 “(ii) to participate, or receive instruc-  
18 tion, in a program of physical exercise, and

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

23 “(B) LIMITATION.—Amounts treated as  
24 medical care under subparagraph (A) shall not



1           exceed \$1,000 with respect to any individual for  
2           any taxable year.”.

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

6 **SEC. 237. CERTAIN NUTRITIONAL AND DIETARY SUPPLE-**  
7 **MENTS TO BE TREATED AS MEDICAL CARE.**

8           (a) **IN GENERAL.**—Subsection (d) of section 213, as  
9 amended by this Act, is amended by adding at the end  
10 the following new paragraph:

11           “(13) **NUTRITIONAL AND DIETARY SUPPLE-**  
12 **MENTS.**—

13           “(A) **IN GENERAL.**—The term ‘medical  
14 care’ shall include amounts paid to purchase  
15 herbs, vitamins, minerals, homeopathic rem-  
16 edies, meal replacement products, and other di-  
17 etary and nutritional supplements.

18           “(B) **LIMITATION.**—Amounts treated as  
19 medical care under subparagraph (A) shall not  
20 exceed \$1,000 with respect to any individual for  
21 any taxable year.

22           “(C) **MEAL REPLACEMENT PRODUCT.**—  
23 For purposes of this paragraph, the term ‘meal  
24 replacement product’ means any product that—

1                   “(i) is permitted to bear labeling mak-  
2                   ing a claim described in section 403(r)(3)  
3                   of the Federal Food, Drug, and Cosmetic  
4                   Act, and

5                   “(ii) is permitted to claim under such  
6                   section that such product is low in fat and  
7                   is a good source of protein, fiber, and mul-  
8                   tiple essential vitamins and minerals.”.

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

12 **SEC. 238. CERTAIN PROVIDER FEES TO BE TREATED AS**  
13 **MEDICAL CARE.**

14           (a) **IN GENERAL.**—Subsection (d) of section 213, as  
15 amended by this Act, is amended by adding at the end  
16 the following new paragraph:

17                   “(14) **PERIODIC PROVIDER FEES.**—The term  
18                   ‘medical care’ shall include periodic fees paid to a  
19                   primary care physician for the right to receive med-  
20                   ical services on an as-needed basis.”.

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

1 **SEC. 239. INCREASE THE MAXIMUM CONTRIBUTION LIMIT**  
2 **TO AN HSA TO MATCH DEDUCTIBLE AND**  
3 **OUT-OF-POCKET EXPENSE LIMITATION.**

4 (a) SELF-ONLY COVERAGE.—Subparagraph (A) of  
5 section 223(b)(2) is amended by striking “\$2,250” and  
6 inserting “the amount in effect under subsection  
7 (c)(2)(A)(ii)(I)”.

8 (b) FAMILY COVERAGE.—Subparagraph (B) of sec-  
9 tion 223(b)(2) is amended by striking “\$4,500” and in-  
10 sserting “the amount in effect under subsection  
11 (c)(2)(A)(ii)(II)”.

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

15 **SEC. 240. CHILD HEALTH SAVINGS ACCOUNT.**

16 (a) IN GENERAL.—Section 223, as amended by this  
17 Act, is amended by adding at the end the following new  
18 subsection:

19 “(j) CHILD HEALTH SAVINGS ACCOUNTS.—

20 “(1) IN GENERAL.—In the case of an indi-  
21 vidual, in addition to any deduction allowed under  
22 subsection (a) for any taxable year, there shall be al-  
23 lowed as a deduction under this section an amount  
24 equal to the aggregate amount paid in cash by the  
25 taxpayer during the taxable year to a child health  
26 savings account of a child of the taxpayer.

1           “(2) LIMITATION.—The amount taken into ac-  
2           count under paragraph (1) with respect to each child  
3           of the taxpayer for the taxable year shall not exceed  
4           an amount equal to \$3,000.

5           “(3) CHILD HEALTH SAVINGS ACCOUNT.—For  
6           purposes of this subsection, the term ‘child health  
7           savings account’ means a health savings account  
8           designated as a child health savings account and es-  
9           tablished for the benefit of a child of a taxpayer, but  
10          only if—

11                   “(A) such account was established for the  
12                   benefit of the child before the child attains the  
13                   age of 5, and

14                   “(B) under the written governing instru-  
15                   ment creating the trust, no contribution will be  
16                   accepted to the extent such contribution, when  
17                   added to previous contributions to the trust for  
18                   the calendar year, exceeds the dollar amount in  
19                   effect under paragraph (2).

20          “(4) TREATMENT OF ACCOUNT BEFORE AGE  
21          18.—For purposes of this section, except as other-  
22          wise provided in this subsection, a child health sav-  
23          ings account established for the benefit of the child  
24          of a taxpayer shall be treated as a health savings ac-  
25          count of the taxpayer until the child attains the age

1 of 18, after which such account shall be treated as  
2 a health savings account of the child.

3 “(5) DISTRIBUTIONS.—

4 “(A) IN GENERAL.—In the case of a child  
5 health savings account established under this  
6 section for the benefit of a child of a tax-  
7 payer—

8 “(i) BEFORE AGE 18.—Any amount  
9 paid or distributed out of such account be-  
10 fore the child has attained the age of 18,  
11 shall be included in the gross income of the  
12 taxpayer, and subparagraph (A) of sub-  
13 section (f) shall apply (relating to addi-  
14 tional tax on distributions not used for  
15 qualified medical expenses).

16 “(ii) AGE 18 AND OLDER.—Any  
17 amount paid or distributed out of such ac-  
18 count after the child has attained the age  
19 of 18 may only be treated as used to pay  
20 qualified medical expenses to the extent  
21 such child is not covered as a dependent  
22 under insurance (other than permitted in-  
23 surance) of a parent.

24 “(B) EXCEPTIONS FOR DISABILITY OR  
25 DEATH OF CHILD.—If the child becomes dis-

1           abled within the meaning of section 72(m)(7) or  
2           dies—

3                   “(i) subparagraph (A) shall not apply  
4                   to any subsequent payment or distribution,  
5                   and

6                   “(ii) the taxpayer may rollover the  
7                   amount in such account to an individual  
8                   retirement plan of the taxpayer, to any  
9                   health savings account of the taxpayer, or  
10                  to any child health savings account of any  
11                  other child of the taxpayer.

12                  “(C) HEALTH INSURANCE MAY BE PUR-  
13                  CHASED FROM ACCOUNT.—Subparagraph (B)  
14                  of subsection (d)(2) shall not apply to any  
15                  health savings account originally established as  
16                  a child health savings account.

17                  “(6) REGULATIONS.—The Secretary shall pre-  
18                  scribe such regulations as may be necessary to carry  
19                  out the purposes of this subsection, including rules  
20                  for determining application of this subsection in the  
21                  case of legal guardians and in the case of parents  
22                  of a child who file separately, are separated, or are  
23                  not married.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2013.

4 **SEC. 241. DISTRIBUTIONS FOR ABORTION EXPENSES FROM**  
5 **HEALTH SAVINGS ACCOUNTS INCLUDED IN**  
6 **GROSS INCOME.**

7 (a) IN GENERAL.—Subsection (f) of section 223 is  
8 amended by adding at the end the following new para-  
9 graph:

10 “(9) EXCEPTION FOR CERTAIN ABORTION EX-  
11 PENSES.—

12 “(A) IN GENERAL.—Notwithstanding para-  
13 graph (1), any amount used to pay for an abor-  
14 tion (other than an abortion described in sub-  
15 paragraph (B)) shall be included in the gross  
16 income of such beneficiary.

17 “(B) EXCEPTIONS.—Subparagraph (A)  
18 shall not apply to—

19 “(i) an abortion—

20 “(I) in the case of a pregnancy  
21 that is the result of an act of rape or  
22 incest, or

23 “(II) in the case where a woman  
24 suffers from a physical disorder, phys-  
25 ical injury, or physical illness that

1 would, as certified by a physician,  
2 place the woman in danger of death  
3 unless an abortion is performed, in-  
4 cluding a life-endangering physical  
5 condition caused by or arising from  
6 the pregnancy, and

7 “(ii) the treatment of any infection,  
8 injury, disease, or disorder that has been  
9 caused by or exacerbated by the perform-  
10 ance of an abortion.”

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

14 **Subtitle C—Enhanced Wellness**  
15 **Incentives**

16 **SEC. 251. PROVIDING FINANCIAL INCENTIVES FOR TREAT-**  
17 **MENT COMPLIANCE.**

18 (a) LIMITATION ON EXCEPTION FOR WELLNESS  
19 PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

20 (1) EMPLOYEE RETIREMENT INCOME SECURITY  
21 ACT OF 1974 AMENDMENT.—Section 702(b)(2) of the  
22 Employee Retirement Income Security Act of 1974  
23 (29 U.S.C. 1182(b)(2)) is amended by adding after  
24 and below subparagraph (B) the following:



1 “In applying subparagraph (B), a group health plan  
2 (or a health insurance issuer with respect to health  
3 insurance coverage) may vary premiums and cost-  
4 sharing by up to 50 percent of the value of the bene-  
5 fits under the plan (or coverage) based on partici-  
6 pation (or lack of participation) in a standards-based  
7 wellness program.”.

8 (2) PHSA AMENDMENT.—Section 2702(b)(2)  
9 of the Public Health Service Act (42 U.S.C. 300gg-  
10 1(b)(2)) is amended by adding after and below sub-  
11 paragraph (B) the following:

12 “In applying subparagraph (B), a group health plan  
13 (or a health insurance issuer with respect to health  
14 insurance coverage) may vary premiums and cost-  
15 sharing by up to 50 percent of the value of the bene-  
16 fits under the plan (or coverage) based on partici-  
17 pation (or lack of participation) in a standards-based  
18 wellness program.”.

19 (3) IRC AMENDMENT.—Section 9802(b)(2) of  
20 the Internal Revenue Code of 1986 is amended by  
21 adding after and below subparagraph (B) the fol-  
22 lowing:

23 “In applying subparagraph (B), a group health plan  
24 may vary premiums and cost-sharing by up to 50  
25 percent of the value of the benefits under the plan

1 based on participation (or lack of participation) in a  
 2 standards-based wellness program.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
 4 subsection (a) shall apply to plan years beginning more  
 5 than 1 year after the date of the enactment of this Act.

6 **TITLE III—IMPROVING ACCESS**  
 7 **TO INSURANCE FOR VULNER-**  
 8 **ABLE AMERICANS**

9 **Subtitle A—Eliminating Barriers to**  
 10 **Insurance Coverage**

11 **SEC. 301. ELIMINATION OF CERTAIN REQUIREMENTS FOR**  
 12 **GUARANTEED AVAILABILITY IN INDIVIDUAL**  
 13 **MARKET.**

14 (a) IN GENERAL.—Section 2741(b) of the Public  
 15 Health Service Act (42 U.S.C. 300gg–41(b)) is amend-  
 16 ed—

17 (1) in paragraph (1)—

18 (A) by striking “(1)(A)” and inserting  
 19 “(1)”; and

20 (B) by striking “and (B)” and all that fol-  
 21 lows up to the semicolon at the end;

22 (2) by adding “and” at the end of paragraph  
 23 (2);

24 (3) in paragraph (3)—

1 (A) by striking “(1)(A)” and inserting  
2 “(1)”; and

3 (B) by striking the semicolon at the end  
4 and inserting a period; and

5 (4) by striking paragraphs (4) and (5).

6 (b) EFFECTIVE DATE.—The amendments made by  
7 subsection (a) shall take effect on the date of the enact-  
8 ment of this Act.

9 **Subtitle B—Ensuring Coverage for**  
10 **Individuals With Preexisting**  
11 **Conditions and Multiple Health**  
12 **Care Needs Through High Risk**  
13 **Pools**

14 **SEC. 311. IMPROVEMENT OF HIGH RISK POOLS.**

15 Section 2745 of the Public Health Service Act (42  
16 U.S.C. 300gg–45) is amended—

17 (1) in subsection (a), by adding at the end the  
18 following: “The Secretary shall provide from the  
19 funds appropriated under subsection (d)(3)(A) a  
20 grant of up to \$5,000,000 to each State that has  
21 not created a qualified high risk pool as of Sep-  
22 tember 1, 2013, for the State’s costs of creation and  
23 initial operation of such a pool.”;

1           (2) in paragraphs (1) and (2) of subsection (b),  
2           by striking “and (2)(A)” and inserting “(2)(A),  
3           (3)(B), and (4)” each place it appears;

4           (3) in subsection (b)(3), by inserting “with re-  
5           spect to funds made available for fiscal years before  
6           fiscal year 2014,” after “applicable standard risks,”;

7           (4) by adding at the end of subsection (b) the  
8           following new paragraph:

9           “(5) VERIFICATION OF CITIZENSHIP OR ALIEN  
10          QUALIFICATION.—

11           “(A) IN GENERAL.—Notwithstanding any  
12           other provision of law, effective upon the date  
13           of the enactment of this paragraph, only citi-  
14           zens and nationals of the United States shall be  
15           eligible to participate in a qualified high risk  
16           pool that receives funds under this section.

17           “(B) CONDITION OF PARTICIPATION.—As  
18           a condition of a State receiving such funds  
19           under this subsection for a fiscal year beginning  
20           with fiscal year 2014, the Secretary shall re-  
21           quire the State to certify, to the satisfaction of  
22           the Secretary, that such State requires all ap-  
23           plicants for coverage in the qualified high risk  
24           pool to provide satisfactory documentation of

1 citizenship or nationality in a manner consistent  
2 with section 1903(x) of the Social Security Act.

3 “(C) RECORDS.—The Secretary shall keep  
4 sufficient records such that a determination of  
5 citizenship or nationality only has to be made  
6 once for any individual under this paragraph.”;

7 and

8 (5) in subsection (d)—

9 (A) in paragraphs (1)(B) and (2) by strik-  
10 ing “paragraph (4)” and inserting “paragraph  
11 (6)”;

12 (B) in paragraph (4), by striking “or (2)”  
13 and inserting “(2), (3)(B), or (4)”;

14 (C) by redesignating paragraphs (3)  
15 through (5) as paragraphs (5) through (7), re-  
16 spectively; and

17 (D) by inserting after paragraph (2) the  
18 following:

19 “(3) AUTHORIZATION OF APPROPRIATIONS FOR  
20 FISCAL YEAR 2014.—There are authorized to be ap-  
21 propriated for fiscal year 2014—

22 “(A) \$50,000,000 to carry out the second  
23 sentence of subsection (a); and

1           “(B) \$2,450,000,000 which, subject to  
2           paragraph (6), shall be made available for allot-  
3           ments under subsection (b)(2).

4           “(4) AUTHORIZATION OF APPROPRIATIONS FOR  
5           FISCAL YEARS 2015 THROUGH 2023.—There are au-  
6           thorized to be appropriated \$2,500,000,000 for each  
7           of fiscal years 2015 through 2023 which, subject to  
8           paragraph (6), shall be made available for allotments  
9           under subsection (b)(2).”.

10 **TITLE IV—ENCOURAGING A**  
11 **MORE COMPETITIVE HEALTH**  
12 **CARE MARKET**

13 **Subtitle A—Expanding Patient**  
14 **Choice**

15 **SEC. 401. COOPERATIVE GOVERNING OF INDIVIDUAL**  
16 **HEALTH INSURANCE COVERAGE.**

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

20           **“PART D—COOPERATIVE GOVERNING OF**  
21 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

22 **“SEC. 2795. DEFINITIONS.**

23           “**In this part:**

24           “(1) PRIMARY STATE.—The term ‘primary  
25           State’ means, with respect to individual health insur-

1       ance coverage offered by a health insurance issuer,  
2       the State designated by the issuer as the State  
3       whose covered laws shall govern the health insurance  
4       issuer in the sale of such coverage under this part.  
5       An issuer, with respect to a particular policy, may  
6       only designate one such State as its primary State  
7       with respect to all such coverage it offers. Such an  
8       issuer may not change the designated primary State  
9       with respect to individual health insurance coverage  
10      once the policy is issued, except that such a change  
11      may be made upon renewal of the policy. With re-  
12      spect to such designated State, the issuer is deemed  
13      to be doing business in that State.

14           “(2) SECONDARY STATE.—The term ‘secondary  
15      State’ means, with respect to individual health insur-  
16      ance coverage offered by a health insurance issuer,  
17      any State that is not the primary State. In the case  
18      of a health insurance issuer that is selling a policy  
19      in, or to a resident of, a secondary State, the issuer  
20      is deemed to be doing business in that secondary  
21      State.

22           “(3) HEALTH INSURANCE ISSUER.—The term  
23      ‘health insurance issuer’ has the meaning given such  
24      term in section 2791(b)(2), except that such an  
25      issuer must be licensed in the primary State and be

1 qualified to sell individual health insurance coverage  
2 in that State.

3 “(4) INDIVIDUAL HEALTH INSURANCE COV-  
4 ERAGE.—The term ‘individual health insurance cov-  
5 erage’ means health insurance coverage offered in  
6 the individual market, as defined in section  
7 2791(e)(1).

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

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

19 “(A) to meet obligations to policyholders  
20 with respect to known claims and reasonably  
21 anticipated claims; or

22 “(B) to pay other obligations in the normal  
23 course of business.

24 “(7) COVERED LAWS.—



1           “(A) IN GENERAL.—The term ‘covered  
2 laws’ means the laws, rules, regulations, agree-  
3 ments, and orders governing the insurance busi-  
4 ness pertaining to—

5           “(i) individual health insurance cov-  
6 erage issued by a health insurance issuer;

7           “(ii) the offer, sale, rating (including  
8 medical underwriting), renewal, and  
9 issuance of individual health insurance cov-  
10 erage to an individual;

11           “(iii) the provision to an individual in  
12 relation to individual health insurance cov-  
13 erage of health care and insurance related  
14 services;

15           “(iv) the provision to an individual in  
16 relation to individual health insurance cov-  
17 erage of management, operations, and in-  
18 vestment activities of a health insurance  
19 issuer; and

20           “(v) the provision to an individual in  
21 relation to individual health insurance cov-  
22 erage of loss control and claims adminis-  
23 tration for a health insurance issuer with  
24 respect to liability for which the issuer pro-  
25 vides insurance.

1           “(B) EXCEPTION.—Such term does not in-  
2           clude any law, rule, regulation, agreement, or  
3           order governing the use of care or cost manage-  
4           ment techniques, including any requirement re-  
5           lated to provider contracting, network access or  
6           adequacy, health care data collection, or quality  
7           assurance.

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

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

15               “(A) Knowingly misrepresenting to claim-  
16               ants and insured individuals relevant facts or  
17               policy provisions relating to coverage at issue.

18               “(B) Failing to acknowledge with reason-  
19               able promptness pertinent communications with  
20               respect to claims arising under policies.

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

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

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

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

10          “(G) A pattern or practice of compelling  
11          insured individuals or their beneficiaries to in-  
12          stitute suits to recover amounts due under its  
13          policies by offering substantially less than the  
14          amounts ultimately recovered in suits brought  
15          by them.

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

23          “(I) Attempting to settle or settling claims  
24          on the basis of an application that was materi-

1           ally altered without notice to, or knowledge or  
2           consent of, the insured.

3           “(J) Failing to provide forms necessary to  
4           present claims within 15 calendar days of a re-  
5           quests with reasonable explanations regarding  
6           their use.

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

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

15                 “(A) Presenting, causing to be presented  
16                 or preparing with knowledge or belief that it  
17                 will be presented to or by an insurer, a rein-  
18                 surer, broker or its agent, false information as  
19                 part of, in support of or concerning a fact ma-  
20                 terial to one or more of the following:

21                         “(i) An application for the issuance or  
22                         renewal of an insurance policy or reinsur-  
23                         ance contract.

24                         “(ii) The rating of an insurance policy  
25                         or reinsurance contract.

1           “(iii) A claim for payment or benefit  
2           pursuant to an insurance policy or reinsur-  
3           ance contract.

4           “(iv) Premiums paid on an insurance  
5           policy or reinsurance contract.

6           “(v) Payments made in accordance  
7           with the terms of an insurance policy or  
8           reinsurance contract.

9           “(vi) A document filed with the com-  
10          missioner or the chief insurance regulatory  
11          official of another jurisdiction.

12          “(vii) The financial condition of an in-  
13          surer or reinsurer.

14          “(viii) The formation, acquisition,  
15          merger, reconsolidation, dissolution or  
16          withdrawal from one or more lines of in-  
17          surance or reinsurance in all or part of a  
18          State by an insurer or reinsurer.

19          “(ix) The issuance of written evidence  
20          of insurance.

21          “(x) The reinstatement of an insur-  
22          ance policy.

23          “(B) Solicitation or acceptance of new or  
24          renewal insurance risks on behalf of an insurer  
25          reinsurer or other person engaged in the busi-

1           ness of insurance by a person who knows or  
2           should know that the insurer or other person  
3           responsible for the risk is insolvent at the time  
4           of the transaction.

5           “(C) Transaction of the business of insur-  
6           ance in violation of laws requiring a license, cer-  
7           tificate of authority or other legal authority for  
8           the transaction of the business of insurance.

9           “(D) Attempt to commit, aiding or abet-  
10          ting in the commission of, or conspiracy to com-  
11          mit the acts or omissions specified in this para-  
12          graph.

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

14          “(a) IN GENERAL.—Except as provided in section  
15   601(e) of the American Health Care Reform Act of 2013,  
16   the covered laws of the primary State shall apply to indi-  
17   vidual health insurance coverage offered by a health insur-  
18   ance issuer in the primary State and in any secondary  
19   State, but only if the coverage and issuer comply with the  
20   conditions of this section with respect to the offering of  
21   coverage in any secondary State.

22          “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
23   ONDARY STATE.—Except as provided in this section, a  
24   health insurance issuer with respect to its offer, sale, rat-  
25   ing (including medical underwriting), renewal, and

1 issuance of individual health insurance coverage in any  
2 secondary State is exempt from any covered laws of the  
3 secondary State (and any rules, regulations, agreements,  
4 or orders sought or issued by such State under or related  
5 to such covered laws) to the extent that such laws would—

6           “(1) make unlawful, or regulate, directly or in-  
7 directly, the operation of the health insurance issuer  
8 operating in the secondary State, except that any  
9 secondary State may require such an issuer—

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

15           “(B) to register with and designate the  
16 State insurance commissioner as its agent solely  
17 for the purpose of receiving service of legal doc-  
18 uments or process;

19           “(C) to submit to an examination of its fi-  
20 nancial condition by the State insurance com-  
21 missioner in any State in which the issuer is  
22 doing business to determine the issuer’s finan-  
23 cial condition, if—

24           “(i) the State insurance commissioner  
25 of the primary State has not done an ex-

1           amination within the period recommended  
2           by the National Association of Insurance  
3           Commissioners; and

4           “(ii) any such examination is con-  
5           ducted in accordance with the examiners’  
6           handbook of the National Association of  
7           Insurance Commissioners and is coordi-  
8           nated to avoid unjustified duplication and  
9           unjustified repetition;

10          “(D) to comply with a lawful order  
11          issued—

12           “(i) in a delinquency proceeding com-  
13           menced by the State insurance commis-  
14           sioner if there has been a finding of finan-  
15           cial impairment under subparagraph (C);  
16           or

17           “(ii) in a voluntary dissolution pro-  
18           ceeding;

19          “(E) to comply with an injunction issued  
20          by a court of competent jurisdiction, upon a pe-  
21          tition by the State insurance commissioner al-  
22          leging that the issuer is in hazardous financial  
23          condition;

24          “(F) to participate, on a nondiscriminatory  
25          basis, in any insurance insolvency guaranty as-



1           society or similar association to which a  
2           health insurance issuer in the State is required  
3           to belong;

4           “(G) to comply with any State law regard-  
5           ing fraud and abuse (as defined in section  
6           2795(10)), except that if the State seeks an in-  
7           junction regarding the conduct described in this  
8           subparagraph, such injunction must be obtained  
9           from a court of competent jurisdiction;

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

13          “(I) to comply with the applicable require-  
14          ments for independent review under section  
15          2798 with respect to coverage offered in the  
16          State;

17          “(2) require any individual health insurance  
18          coverage issued by the issuer to be countersigned by  
19          an insurance agent or broker residing in that Sec-  
20          ondary State; or

21          “(3) otherwise discriminate against the issuer  
22          issuing insurance in both the primary State and in  
23          any secondary State.

24          “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
25          health insurance issuer shall provide the following notice,

1 in 12-point bold type, in any insurance coverage offered  
2 in a secondary State under this part by such a health in-  
3 surance issuer and at renewal of the policy, with the 5  
4 blank spaces therein being appropriately filled with the  
5 name of the health insurance issuer, the name of primary  
6 State, the name of the secondary State, the name of the  
7 secondary State, and the name of the secondary State, re-  
8 spectively, for the coverage concerned:

9

## “NOTICE

10 “This policy is issued by \_\_\_\_\_ and is gov-  
11 erned by the laws and regulations of the State of  
12 \_\_\_\_\_, and it has met all the laws of that State as  
13 determined by that State’s Department of Insurance. This  
14 policy may be less expensive than others because it is not  
15 subject to all of the insurance laws and regulations of the  
16 State of \_\_\_\_\_, including coverage of some services  
17 or benefits mandated by the law of the State of  
18 \_\_\_\_\_. Additionally, this policy is not subject to all  
19 of the consumer protection laws or restrictions on rate  
20 changes of the State of \_\_\_\_\_. As with all insurance  
21 products, before purchasing this policy, you should care-  
22 fully review the policy and determine what health care  
23 services the policy covers and what benefits it provides,  
24 including any exclusions, limitations, or conditions for  
25 such services or benefits.’.

1       “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
2 AND PREMIUM INCREASES.—

3           “(1) IN GENERAL.—For purposes of this sec-  
4 tion, a health insurance issuer that provides indi-  
5 vidual health insurance coverage to an individual  
6 under this part in a primary or secondary State may  
7 not upon renewal—

8           “(A) move or reclassify the individual in-  
9 sured under the health insurance coverage from  
10 the class such individual is in at the time of  
11 issue of the contract based on the health-status  
12 related factors of the individual; or

13           “(B) increase the premiums assessed the  
14 individual for such coverage based on a health  
15 status-related factor or change of a health sta-  
16 tus-related factor or the past or prospective  
17 claim experience of the insured individual.

18           “(2) CONSTRUCTION.—Nothing in paragraph  
19 (1) shall be construed to prohibit a health insurance  
20 issuer—

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

1           “(B) from raising premium rates for all  
2 policy holders within a class based on claims ex-  
3 perience;

4           “(C) from changing premiums or offering  
5 discounted premiums to individuals who engage  
6 in wellness activities at intervals prescribed by  
7 the issuer, if such premium changes or incen-  
8 tives—

9                   “(i) are disclosed to the consumer in  
10 the insurance contract;

11                   “(ii) are based on specific wellness ac-  
12 tivities that are not applicable to all indi-  
13 viduals; and

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

16           “(D) from reinstating lapsed coverage; or

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

21           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
22 STATE.—A health insurance issuer may not offer for sale  
23 individual health insurance coverage in a secondary State  
24 unless that coverage is currently offered for sale in the  
25 primary State.

1       “(f) LICENSING OF AGENTS OR BROKERS FOR  
2 HEALTH INSURANCE ISSUERS.—Any State may require  
3 that a person acting, or offering to act, as an agent or  
4 broker for a health insurance issuer with respect to the  
5 offering of individual health insurance coverage obtain a  
6 license from that State, with commissions or other com-  
7 pensation subject to the provisions of the laws of that  
8 State, except that a State may not impose any qualifica-  
9 tion or requirement which discriminates against a non-  
10 resident agent or broker.

11       “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
12 SURANCE COMMISSIONER.—Each health insurance issuer  
13 issuing individual health insurance coverage in both pri-  
14 mary and secondary States shall submit—

15               “(1) to the insurance commissioner of each  
16 State in which it intends to offer such coverage, be-  
17 fore it may offer individual health insurance cov-  
18 erage in such State—

19                       “(A) a copy of the plan of operation or fea-  
20 sibility study or any similar statement of the  
21 policy being offered and its coverage (which  
22 shall include the name of its primary State and  
23 its principal place of business);

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

1           “(C) written notice from the issuer of the  
2           issuer’s compliance with all the laws of the pri-  
3           mary State; and

4           “(2) to the insurance commissioner of each sec-  
5           ondary State in which it offers individual health in-  
6           surance coverage, a copy of the issuer’s quarterly fi-  
7           nancial statement submitted to the primary State,  
8           which statement shall be certified by an independent  
9           public accountant and contain a statement of opin-  
10          ion on loss and loss adjustment expense reserves  
11          made by—

12                   “(A) a member of the American Academy  
13                   of Actuaries; or

14                   “(B) a qualified loss reserve specialist.

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

18                   “(1) the solicitation or sale of individual health  
19                   insurance coverage by a health insurance issuer to  
20                   any person or group who is not eligible for such in-  
21                   surance; or

22                   “(2) the solicitation or sale of individual health  
23                   insurance coverage that violates the requirements of  
24                   the law of a secondary State which are described in

1 subparagraphs (A) through (H) of section  
2 2796(b)(1).

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

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

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

16 “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

24 “(l) GENERALLY APPLICABLE LAWS.—Nothing in  
25 this section shall be construed to affect the applicability

1 of State laws generally applicable to persons or corpora-  
2 tions.

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

16 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
17 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
18 **STATES.**

19 “A health insurance issuer may not offer, sell, or  
20 issue individual health insurance coverage in a secondary  
21 State if the State insurance commissioner does not use  
22 a risk-based capital formula for the determination of cap-  
23 ital and surplus requirements for all health insurance  
24 issuers.



1 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
2 **DURES.**

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

7 “(1) both the secondary State and the primary  
8 State have legislation or regulations in place estab-  
9 lishing an independent review process for individuals  
10 who are covered by individual health insurance cov-  
11 erage, or

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

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

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

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

11           “(B) with respect to each review, each re-  
12 viewer meets the requirements of paragraph (4)  
13 and the reviewer, or at least 1 reviewer on the  
14 panel, meets the requirements described in  
15 paragraph (5); and

16           “(C) compensation provided by the issuer  
17 to each reviewer is consistent with paragraph  
18 (6).

19       “(2) LICENSURE AND EXPERTISE.—Each inde-  
20 pendent medical reviewer shall be a physician  
21 (allopathic or osteopathic) or health care profes-  
22 sional who—

23           “(A) is appropriately credentialed or li-  
24 censed in 1 or more States to deliver health  
25 care services; and

1           “(B) typically treats the condition, makes  
2 the diagnosis, or provides the type of treatment  
3 under review.

4           “(3) INDEPENDENCE.—

5           “(A) IN GENERAL.—Subject to subpara-  
6 graph (B), each independent medical reviewer  
7 in a case shall—

8                   “(i) not be a related party (as defined  
9 in paragraph (7));

10                   “(ii) not have a material familial, fi-  
11 nancial, or professional relationship with  
12 such a party; and

13                   “(iii) not otherwise have a conflict of  
14 interest with such a party (as determined  
15 under regulations).

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

18                   “(i) prohibit an individual, solely on  
19 the basis of affiliation with the issuer,  
20 from serving as an independent medical re-  
21 viewer if—

22                           “(I) a non-affiliated individual is  
23 not reasonably available;

1           “(II) the affiliated individual is  
2 not involved in the provision of items  
3 or services in the case under review;

4           “(III) the fact of such an affili-  
5 ation is disclosed to the issuer and the  
6 enrollee (or authorized representative)  
7 and neither party objects; and

8           “(IV) the affiliated individual is  
9 not an employee of the issuer and  
10 does not provide services exclusively or  
11 primarily to or on behalf of the issuer;

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

20           “(iii) prohibit receipt of compensation  
21 by an independent medical reviewer from  
22 an entity if the compensation is provided  
23 consistent with paragraph (6).

24           “(4) PRACTICING HEALTH CARE PROFESSIONAL  
25 IN SAME FIELD.—

1           “(A) IN GENERAL.—In a case involving  
2 treatment, or the provision of items or serv-  
3 ices—

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

13           “(ii) by a non-physician health care  
14 professional, the reviewer, or at least 1  
15 member of the review panel, shall be a  
16 practicing non-physician health care pro-  
17 fessional of the same or similar specialty  
18 as the non-physician health care profes-  
19 sional who, acting within the appropriate  
20 scope of practice within the State in which  
21 the service is provided or rendered, typi-  
22 cally treats the condition, makes the diag-  
23 nosis, or provides the type of treatment  
24 under review.

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

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

11          “(6) LIMITATIONS ON REVIEWER COMPENSA-  
12          TION.—Compensation provided by the issuer to an  
13          independent medical reviewer in connection with a  
14          review under this section shall—

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

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

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

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

24                 “(B) The enrollee (or authorized represent-  
25                 ative).

1           “(C) The health care professional that pro-  
2           vides the items or services involved in the de-  
3           nial.

4           “(D) The institution at which the items or  
5           services (or treatment) involved in the denial  
6           are provided.

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

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

13           “(8) DEFINITIONS.—For purposes of this sub-  
14           section:

15           “(A) ENROLLEE.—The term ‘enrollee’  
16           means, with respect to health insurance cov-  
17           erage offered by a health insurance issuer, an  
18           individual enrolled with the issuer to receive  
19           such coverage.

20           “(B) HEALTH CARE PROFESSIONAL.—The  
21           term ‘health care professional’ means an indi-  
22           vidual who is licensed, accredited, or certified  
23           under State law to provide specified health care  
24           services and who is operating within the scope  
25           of such licensure, accreditation, or certification.

1 **“SEC. 2799. ENFORCEMENT.**

2       “(a) IN GENERAL.—Subject to subsection (b) and ex-  
3 cept as provided in section 601(c) of the American Health  
4 Care Reform Act of 2013, with respect to specific indi-  
5 vidual health insurance coverage the primary State for  
6 such coverage has sole jurisdiction to enforce the primary  
7 State’s covered laws in the primary State and any sec-  
8 ondary State.

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

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

17       “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
18 of individual health insurance coverage offered in a sec-  
19 ondary State that fails to comply with the covered laws  
20 of the primary State, the applicable State authority of the  
21 secondary State may notify the applicable State authority  
22 of the primary State.”.

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



1 (c) GAO ONGOING STUDY AND REPORTS.—

2 (1) STUDY.—The Comptroller General of the  
3 United States shall conduct an ongoing study con-  
4 cerning the effect of the amendment made by sub-  
5 section (a) on—

6 (A) the number of uninsured and under-in-  
7 sured;

8 (B) the availability and cost of health in-  
9 surance policies for individuals with pre-existing  
10 medical conditions;

11 (C) the availability and cost of health in-  
12 surance policies generally;

13 (D) the elimination or reduction of dif-  
14 ferent types of benefits under health insurance  
15 policies offered in different States; and

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

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

1       **Subtitle B—McCarran-Ferguson**  
2                                   **Reform**

3       **SEC. 411. RESTORING THE APPLICATION OF ANTITRUST**  
4                                   **LAWS TO HEALTH SECTOR INSURERS.**

5           (a) AMENDMENT TO MCCARRAN-FERGUSON ACT.—

6       Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013),  
7       commonly known as the McCarran-Ferguson Act, is  
8       amended by adding at the end the following:

9           “(c)(1) Nothing contained in this Act shall modify,  
10       impair, or supersede the operation of any of the antitrust  
11       laws with respect to the business of health insurance (in-  
12       cluding the business of dental insurance). For purposes  
13       of the preceding sentence, the term ‘antitrust laws’ has  
14       the meaning given it in subsection (a) of the first section  
15       of the Clayton Act, except that such term includes section  
16       5 of the Federal Trade Commission Act to the extent that  
17       such section 5 applies to unfair methods of competition.

18           “(2) For purposes of paragraph (1), the term ‘busi-  
19       ness of health insurance (including the business of dental  
20       insurance)’ does not include—

21                   “(A) the business of life insurance (including  
22                   annuities); or

23                   “(B) the business of property or casualty insur-  
24                   ance, including but not limited to, any insurance or  
25                   benefits defined as ‘excepted benefits’ under para-

1 graph (1), subparagraphs (B) or (C) of paragraph  
2 (2), or paragraph (3) of section 9832(e) of the In-  
3 ternal Revenue Code of 1986 (26 U.S.C. 9832(e))  
4 whether offered separately or in combination with  
5 insurance or benefits described in paragraph (2)(A)  
6 of such section.”.

7 (b) RELATED PROVISION.—For purposes of section  
8 5 of the Federal Trade Commission Act (15 U.S.C. 45)  
9 to the extent such section applies to unfair methods of  
10 competition, section 3(c) of the McCarran-Ferguson Act  
11 shall apply with respect to the business of health insurance  
12 without regard to whether such business is carried on for  
13 profit, notwithstanding the definition of “Corporation”  
14 contained in section 4 of the Federal Trade Commission  
15 Act.

## 16 **Subtitle C—Medicare Price** 17 **Transparency**

18 **SEC. 421. PUBLIC AVAILABILITY OF MEDICARE CLAIMS**

19 **DATA.**

20 (a) IN GENERAL.—Section 1128J of the Social Secu-  
21 rity Act (42 U.S.C. 1320a–7k) is amended by adding at  
22 the end the following new subsection:

23 “(f) PUBLIC AVAILABILITY OF MEDICARE CLAIMS  
24 DATA.—

1           “(1) IN GENERAL.—The Secretary shall, to the  
2 extent consistent with applicable information, pri-  
3 vacy, security, and disclosure laws, including the  
4 regulations promulgated under the Health Insurance  
5 Portability and Accountability Act of 1996 and sec-  
6 tion 552a of title 5, United States Code, make avail-  
7 able to the public claims and payment data of the  
8 Department of Health and Human Services related  
9 to title XVIII, including data on payments made to  
10 any provider of services or supplier under such title.

11           “(2) IMPLEMENTATION.—

12           “(A) IN GENERAL.—Not later than De-  
13 cember 31, 2014, the Secretary shall promul-  
14 gate regulations to carry out this subsection.

15           “(B) REQUIREMENTS.—The regulations  
16 promulgated under subparagraph (A) shall en-  
17 sure that—

18           “(i) the data described in paragraph  
19 (1) is made available to the public through  
20 a searchable database that the public can  
21 access at no cost;

22           “(ii) such database—

23           “(I) includes the amount paid to  
24 each provider of services or supplier  
25 under title XVIII, the items or serv-

1           ices for which such payment was  
2           made, and the location of the provider  
3           of services or supplier;

4           “(II) is organized based on the  
5           specialty or the type of provider of  
6           services or supplier involved;

7           “(III) is searchable based on the  
8           type of items or services furnished;  
9           and

10          “(IV) includes a disclaimer that  
11          the aggregate data in the database  
12          does not reflect on the quality of the  
13          items or services furnished or of the  
14          provider of services or supplier who  
15          furnished the items or services; and

16          “(iii) each provider of services or sup-  
17          plier in the database is identified by a  
18          unique identifier that is available to the  
19          public (such as the National Provider Iden-  
20          tifier of the provider of services or sup-  
21          plier).

22          “(C) SCOPE OF DATA.—The database shall  
23          include data for fiscal year 2014, and each year  
24          fiscal year thereafter.”.

1 (b) INFORMATION NOT EXEMPT UNDER THE FREE-  
 2 DOM OF INFORMATION ACT.—The term “personnel and  
 3 medical files and similar files the disclosure of which  
 4 would constitute a clearly unwarranted invasion of per-  
 5 sonal privacy”, as used in section 552(b)(6) of title 5,  
 6 United States Code, does not include the information re-  
 7 quired to be made available to the public under section  
 8 1128J(f) of the Social Security Act, as added by sub-  
 9 section (a).

## 10 **Subtitle D—State Transparency** 11 **Portals**

### 12 **SEC. 431. PROVIDING INFORMATION ON HEALTH COV-** 13 **ERAGE OPTIONS AND HEALTH CARE PRO-** 14 **VIDERS.**

15 (a) STATE-BASED PORTAL.—A State (by itself or  
 16 jointly with other States) may contract with a private enti-  
 17 ty to establish a Health Plan and Provider Portal Web  
 18 site (referred to in this section as a “plan portal”) for  
 19 the purposes of providing standardized information—

20 (1) on health insurance plans that have been  
 21 certified to be available for purchase in that State;  
 22 and

23 (2) on price and quality information on health  
 24 care providers (including physicians, hospitals, and  
 25 other health care institutions).

1 (b) PROHIBITIONS.—

2 (1) DIRECT ENROLLMENT.—A plan portal may  
3 not directly enroll individuals in health insurance  
4 plans or under a State Medicaid plan or a State  
5 children’s health insurance plan.

6 (2) CONFLICTS OF INTEREST.—

7 (A) COMPANIES.—A health insurance  
8 issuer offering a health insurance plan through  
9 a plan portal may not—

10 (i) be the private entity developing  
11 and maintaining a plan portal under this  
12 section; or

13 (ii) have an ownership interest in such  
14 private entity or in the plan portal.

15 (B) INDIVIDUALS.—An individual em-  
16 ployed by a health insurance issuer offering a  
17 health insurance plan through a plan portal  
18 may not serve as a director or officer for—

19 (i) the private entity developing and  
20 maintaining a plan portal under this sec-  
21 tion; or

22 (ii) the plan portal.

23 (c) CONSTRUCTION.—Nothing in this section shall be  
24 construed to prohibit health insurance brokers and agents  
25 from—

1           (1) utilizing the plan portal for any purpose; or  
2           (2) marketing or offering health insurance  
3 products.

4           (d) STATE DEFINED.—In this section, the term  
5 “State” has the meaning given such term for purposes of  
6 title XIX of the Social Security Act.

7           (e) HEALTH INSURANCE PLANS.—For purposes of  
8 this section, the term “health insurance plan” does not  
9 include coverage of excepted benefits, as defined in section  
10 2791(c) of the Public Health Service Act (42 U.S.C.  
11 300gg–91(e)).

12          (f) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated \$50,000,000 for fiscal  
14 year 2014 to provide funding for the Secretary of Health  
15 and Human Services to award grants to States to enter  
16 into contracts to establish a portal plan under this section,  
17 to remain available until expended.

18       **Subtitle E—Protecting the Doctor-**  
19                       **Patient Relationship**

20       **SEC. 441. RULE OF CONSTRUCTION.**

21           Nothing in this Act shall be construed to interfere  
22 with the doctor-patient relationship or the practice of med-  
23 icine.



1 **SEC. 442. REPEAL OF FEDERAL COORDINATING COUNCIL**  
 2 **FOR COMPARATIVE EFFECTIVENESS RE-**  
 3 **SEARCH.**

4 Effective on the date of the enactment of this Act,  
 5 section 804 of the American Recovery and Reinvestment  
 6 Act of 2009 is repealed.

7 **Subtitle F—Association Health**  
 8 **Plans**

9 **SEC. 451. RULES GOVERNING ASSOCIATION HEALTH**  
 10 **PLANS.**

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

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

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

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

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

23 “(1) is organized and maintained in good faith,  
 24 with a constitution and bylaws specifically stating its  
 25 purpose and providing for periodic meetings on at  
 26 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 part,

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 part.

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 part, an  
22       affiliated member of the sponsor of the plan may be of-  
23       fered coverage under the plan as a participating employer  
24       only 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, (2) any law of the State with which  
7 filing and approval of a policy type offered by the plan  
8 was initially obtained to the extent that such law prohibits  
9 an exclusion of a specific disease from such coverage, or  
10 (3) any law described in section 601(c) of the American  
11 Health Care Reform Act of 2013.

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

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

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

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

23 “(A) establishes and maintains reserves  
24 with respect to such additional benefit options,



1 in amounts recommended by the qualified actu-  
2 ary, consisting of—

3 “(i) a reserve sufficient for unearned  
4 contributions;

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

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

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

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

22 “(i) The plan shall secure aggregate  
23 excess/stop loss insurance for the plan with  
24 an attachment point which is not greater  
25 than 125 percent of expected gross annual

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

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

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

23 Any person issuing to a plan insurance described in clause  
24 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
25 retary of any failure of premium payment meriting can-

1 cellation of the policy prior to undertaking such a cancella-  
2 tion. Any regulations prescribed by the applicable author-  
3 ity pursuant to clause (i) or (ii) of subparagraph (B) may  
4 allow for such adjustments in the required levels of excess/  
5 stop loss insurance as the qualified actuary may rec-  
6 ommend, taking into account the specific circumstances  
7 of the plan.

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

13 “(1) \$500,000, or

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

23 “(c) ADDITIONAL REQUIREMENTS.—In the case of  
24 any association health plan described in subsection (a)(2),  
25 the applicable authority may provide such additional re-

1 requirements relating to reserves, excess/stop loss insurance,  
2 and indemnification insurance as the applicable authority  
3 considers appropriate. Such requirements may be provided  
4 by regulation with respect to any such plan or any class  
5 of such plans.

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

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

1 dence may be in the form of a contract of indemnification,  
2 lien, bonding, insurance, letter of credit, recourse under  
3 applicable terms of the plan in the form of assessments  
4 of participating employers, security, or other financial ar-  
5 rangement.

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

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

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

1 sets are distributed pursuant to a termination  
2 procedure.

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

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

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

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

12           “(3) ASSOCIATION HEALTH PLAN FUND.—

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

23                   “(B) INVESTMENT.—Whenever the Sec-  
24                   retary determines that the moneys of the fund  
25                   are in excess of current needs, the Secretary

1           may request the investment of such amounts as  
2           the Secretary determines advisable by the Sec-  
3           retary of the Treasury in obligations issued or  
4           guaranteed by the United States.

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

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

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

17           “(B) which is guaranteed renewable; and

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

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



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

9           “(B) which is guaranteed renewable; and

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

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

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

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

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

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

12          “(j) SOLVENCY STANDARDS WORKING GROUP.—

13           “(1) IN GENERAL.—Within 90 days after the  
14           date of the enactment of this part, the applicable au-  
15           thority shall establish a Solvency Standards Working  
16           Group. In prescribing the initial regulations under  
17           this section, the applicable authority shall take into  
18           account the recommendations of such Working  
19           Group.

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

1           “(A) a representative of the National Asso-  
2           ciation of Insurance Commissioners;

3           “(B) a representative of the American  
4           Academy of Actuaries;

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

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

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

12          “(F) a representative of multiemployer  
13          plans that are group health plans, or their in-  
14          terests.

15 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
16 **LATED REQUIREMENTS.**

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

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

7           “(1) IDENTIFYING INFORMATION.—The names  
8       and addresses of—

9                   “(A) the sponsor; and

10                   “(B) the members of the board of trustees  
11       of the plan.

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

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

22           “(4) PLAN DOCUMENTS.—A copy of the docu-  
23 ments governing the plan (including any bylaws and  
24 trust agreements), the summary plan description,  
25 and other material describing the benefits that will

1 be provided to participants and beneficiaries under  
2 the plan.

3 “(5) AGREEMENTS WITH SERVICE PRO-  
4 VIDERS.—A copy of any agreements between the  
5 plan and contract administrators and other service  
6 providers.

7 “(6) FUNDING REPORT.—In the case of asso-  
8 ciation health plans providing benefits options in ad-  
9 dition to health insurance coverage, a report setting  
10 forth information with respect to such additional  
11 benefit options determined as of a date within the  
12 120-day period ending with the date of the applica-  
13 tion, including the following:

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

21 “(B) ADEQUACY OF CONTRIBUTION  
22 RATES.—A statement of actuarial opinion,  
23 signed by a qualified actuary, which sets forth  
24 a description of the extent to which contribution  
25 rates are adequate to provide for the payment

1 of all obligations and the maintenance of re-  
2 quired reserves under the plan for the 12-  
3 month period beginning with such date within  
4 such 120-day period, taking into account the  
5 expected coverage and experience of the plan. If  
6 the contribution rates are not fully adequate,  
7 the statement of actuarial opinion shall indicate  
8 the extent to which the rates are inadequate  
9 and the changes needed to ensure adequacy.

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

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

1           “(E) OTHER INFORMATION.—Any other  
2           information as may be determined by the appli-  
3           cable authority, by regulation, as necessary to  
4           carry out the purposes of this part.

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

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

1       “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
2 SOCIATION HEALTH PLANS.—An association health plan  
3 certified under this part which provides benefit options in  
4 addition to health insurance coverage for such plan year  
5 shall meet the requirements of section 103 by filing an  
6 annual report under such section which shall include infor-  
7 mation described in subsection (b)(6) with respect to the  
8 plan year and, notwithstanding section 104(a)(1)(A), shall  
9 be filed with the applicable authority not later than 90  
10 days after the close of the plan year (or on such later date  
11 as may be prescribed by the applicable authority). The ap-  
12 plicable authority may require by regulation such interim  
13 reports as it considers appropriate.

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



1 whether the contents of the matters reported under this  
2 part—

3 “(1) are in the aggregate reasonably related to  
4 the experience of the plan and to reasonable expecta-  
5 tions; and

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

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

10 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
11 **MINATION.**

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

18 “(1) provides to the participants and bene-  
19 ficiaries a written notice of intent to terminate stat-  
20 ing that such termination is intended and the pro-  
21 posed termination date;

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

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

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

6   **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-  
7                                    NATION.**

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

1 actions, the board shall notify the applicable authority (in  
2 such form and manner as the applicable authority may  
3 prescribe by regulation) of such recommendations of the  
4 actuary for corrective action, together with a description  
5 of the actions (if any) that the board has taken or plans  
6 to take in response to such recommendations. The board  
7 shall thereafter report to the applicable authority, in such  
8 form and frequency as the applicable authority may speci-  
9 fy to the board, regarding corrective action taken by the  
10 board until the requirements of section 806 are met.

11 “(b) MANDATORY TERMINATION.—In any case in  
12 which—

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

23 “(2) the applicable authority determines that  
24 there is a reasonable expectation that the plan will

1 continue to fail to meet the requirements of section  
2 806,  
3 the board of trustees of the plan shall, at the direction  
4 of the applicable authority, terminate the plan and, in the  
5 course of the termination, take such actions as the appli-  
6 cable authority may require, including satisfying any  
7 claims referred to in section 806(a)(2)(B)(iii) and recov-  
8 ering for the plan any liability under subsection  
9 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
10 that the affairs of the plan will be, to the maximum extent  
11 possible, wound up in a manner which will result in timely  
12 provision of all benefits for which the plan is obligated.

13 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
14 **VENT ASSOCIATION HEALTH PLANS PRO-**  
15 **VIDING HEALTH BENEFITS IN ADDITION TO**  
16 **HEALTH INSURANCE COVERAGE.**

17 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
18 INSOLVENT PLANS.—Whenever the Secretary determines  
19 that an association health plan which is or has been cer-  
20 tified under this part and which is described in section  
21 806(a)(2) will be unable to provide benefits when due or  
22 is otherwise in a financially hazardous condition, as shall  
23 be defined by the Secretary by regulation, the Secretary  
24 shall, upon notice to the plan, apply to the appropriate  
25 United States district court for appointment of the Sec-

1 retary as trustee to administer the plan for the duration  
2 of the insolvency. The plan may appear as a party and  
3 other interested persons may intervene in the proceedings  
4 at the discretion of the court. The court shall appoint such  
5 Secretary trustee if the court determines that the trustee-  
6 ship is necessary to protect the interests of the partici-  
7 pants and beneficiaries or providers of medical care or to  
8 avoid any unreasonable deterioration of the financial con-  
9 dition of the plan. The trusteeship of such Secretary shall  
10 continue until the conditions described in the first sen-  
11 tence of this subsection are remedied or the plan is termi-  
12 nated.

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

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

19               “(2) to require the transfer of all (or any part)  
20 of the assets and records of the plan to the Sec-  
21 retary as trustee;

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

1           “(4) to require the sponsor, the plan adminis-  
2           trator, any participating employer, and any employee  
3           organization representing plan participants to fur-  
4           nish any information with respect to the plan which  
5           the Secretary as trustee may reasonably need in  
6           order to administer the plan;

7           “(5) to collect for the plan any amounts due the  
8           plan and to recover reasonable expenses of the trust-  
9           eeship;

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

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

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

22           “(9) to provide for the enrollment of plan par-  
23           ticipants and beneficiaries under appropriate cov-  
24           erage options; and

1           “(10) to do such other acts as may be nec-  
2           essary to comply with this title or any order of the  
3           court and to protect the interests of plan partici-  
4           pants and beneficiaries and providers of medical  
5           care.

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

9                   “(1) the sponsor and plan administrator;

10                   “(2) each participant;

11                   “(3) each participating employer; and

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

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

22           “(e) OTHER PROCEEDINGS.—An application by the  
23           Secretary under this subsection may be filed notwith-  
24           standing the pendency in the same or any other court of  
25           any bankruptcy, mortgage foreclosure, or equity receiver-

1 ship proceeding, or any proceeding to reorganize, conserve,  
2 or liquidate such plan or its property, or any proceeding  
3 to enforce a lien against property of the plan.

4 “(f) JURISDICTION OF COURT.—

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



1 sponsor or any other suit against the plan or the  
2 sponsor.

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

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

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

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

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

1           “(1) such tax is computed by applying a rate to  
2           the amount of premiums or contributions, with re-  
3           spect to individuals covered under the plan who are  
4           residents of such State, which are received by the  
5           plan from participating employers located in such  
6           State or from such individuals;

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

13          “(3) such tax is otherwise nondiscriminatory;  
14          and

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

1       vided by such insurers or health maintenance organi-  
2       zations in such State in connection with such plan.

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

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

5               “(1) GROUP HEALTH PLAN.—The term ‘group  
6       health plan’ has the meaning provided in section  
7       733(a)(1) (after applying subsection (b) of this sec-  
8       tion).

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

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

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

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

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

4           “(7) INDIVIDUAL MARKET.—

5           “(A) IN GENERAL.—The term ‘individual  
6 market’ means the market for health insurance  
7 coverage offered to individuals other than in  
8 connection with a group health plan.

9           “(B) TREATMENT OF VERY SMALL  
10 GROUPS.—

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

18           “(ii) STATE EXCEPTION.—Clause (i)  
19 shall not apply in the case of health insur-  
20 ance coverage offered in a State if such  
21 State regulates the coverage described in  
22 such clause in the same manner and to the  
23 same extent as coverage in the small group  
24 market (as defined in section 2791(e)(5) of

1           the Public Health Service Act) is regulated  
2           by such State.

3           “(8) PARTICIPATING EMPLOYER.—The term  
4           ‘participating employer’ means, in connection with  
5           an association health plan, any employer, if any indi-  
6           vidual who is an employee of such employer, a part-  
7           ner in such employer, or a self-employed individual  
8           who is such employer (or any dependent, as defined  
9           under the terms of the plan, of such individual) is  
10          or was covered under such plan in connection with  
11          the status of such individual as such an employee,  
12          partner, or self-employed individual in relation to the  
13          plan.

14          “(9) APPLICABLE STATE AUTHORITY.—The  
15          term ‘applicable State authority’ means, with respect  
16          to a health insurance issuer in a State, the State in-  
17          surance commissioner or official or officials des-  
18          ignated by the State to enforce the requirements of  
19          title XXVII of the Public Health Service Act for the  
20          State involved with respect to such issuer.

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

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

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

4           “(B) in the case of a sponsor with mem-  
5           bers which consist of associations, a person who  
6           is a member of any such association and elects  
7           an affiliated status with the sponsor, or

8           “(C) in the case of an association health  
9           plan in existence on the date of the enactment  
10          of this part, a person eligible to be a member  
11          of the sponsor or one of its member associa-  
12          tions.

13          “(12) LARGE EMPLOYER.—The term ‘large em-  
14          ployer’ means, in connection with a group health  
15          plan with respect to a plan year, an employer who  
16          employed an average of at least 51 employees on  
17          business days during the preceding calendar year  
18          and who employs at least 2 employees on the first  
19          day of the plan year.

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

24          “(b) RULES OF CONSTRUCTION.—

1           “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
2           poses of determining whether a plan, fund, or pro-  
3           gram is an employee welfare benefit plan which is an  
4           association health plan, and for purposes of applying  
5           this title in connection with such plan, fund, or pro-  
6           gram so determined to be such an employee welfare  
7           benefit plan—

8                   “(A) in the case of a partnership, the term  
9                   ‘employer’ (as defined in section 3(5)) includes  
10                  the partnership in relation to the partners, and  
11                  the term ‘employee’ (as defined in section 3(6))  
12                  includes any partner in relation to the partner-  
13                  ship; and

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

18           “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
19           AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
20           case of any plan, fund, or program which was estab-  
21           lished or is maintained for the purpose of providing  
22           medical care (through the purchase of insurance or  
23           otherwise) for employees (or their dependents) cov-  
24           ered thereunder and which demonstrates to the Sec-  
25           retary that all requirements for certification under

1 this part would be met with respect to such plan,  
2 fund, or program if such plan, fund, or program  
3 were a group health plan, such plan, fund, or pro-  
4 gram shall be treated for purposes of this title as an  
5 employee welfare benefit plan on and after the date  
6 of such demonstration.”.

7 (b) CONFORMING AMENDMENTS TO PREEMPTION  
8 RULES.—

9 (1) Section 514(b)(6) of such Act (29 U.S.C.  
10 1144(b)(6)) is amended by adding at the end the  
11 following new subparagraph:

12 “(E) The preceding subparagraphs of this paragraph  
13 do not apply with respect to any State law in the case  
14 of an association health plan which is certified under part  
15 8.”.

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

18 (A) in subsection (b)(4), by striking “Sub-  
19 section (a)” and inserting “Subsections (a) and  
20 (f)”;

21 (B) in subsection (b)(5), by striking “sub-  
22 section (a)” in subparagraph (A) and inserting  
23 “subsection (a) of this section and subsections  
24 (a)(2)(B) and (b) of section 805”, and by strik-  
25 ing “subsection (a)” in subparagraph (B) and



1 inserting “subsection (a) of this section or sub-  
2 section (a)(2)(B) or (b) of section 805”; and

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

5 “(f)(1) Except as provided in subsection (b)(4), the  
6 provisions of this title shall supersede any and all State  
7 laws insofar as they may now or hereafter preclude, or  
8 have the effect of precluding, a health insurance issuer  
9 from offering health insurance coverage in connection with  
10 an association health plan which is certified under part  
11 8.

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

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

1           “(B) In any case in which health insurance cov-  
2           erage of any policy type is offered in a State under  
3           an association health plan certified under part 8 and  
4           the filing, with the applicable State authority (as de-  
5           fined in section 812(a)(9)), of the policy form in  
6           connection with such policy type is approved by such  
7           State authority, the provisions of this title shall su-  
8           persede any and all laws of any other State in which  
9           health insurance coverage of such type is offered, in-  
10          sofar as they may preclude, upon the filing in the  
11          same form and manner of such policy form with the  
12          applicable State authority in such other State, the  
13          approval of the filing in such other State.

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

18                 “(A) providing solvency standards or similar  
19                 standards regarding the adequacy of insurer capital,  
20                 surplus, reserves, or contributions, or

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

22          “(4) For additional provisions relating to association  
23          health plans, see subsections (a)(2)(B) and (b) of section  
24          805.

1       “(5) For purposes of this subsection, the term ‘asso-  
2 ciation health plan’ has the meaning provided in section  
3 801(a), and the terms ‘health insurance coverage’, ‘par-  
4 ticipating employer’, and ‘health insurance issuer’ have  
5 the meanings provided such terms in section 812, respec-  
6 tively.”.

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

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

11           (B) in clause (ii), by inserting “and which  
12 does not provide medical care (within the mean-  
13 ing of section 733(a)(2)),” after “arrange-  
14 ment,”, and by striking “title.” and inserting  
15 “title, and”; and

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

18           “(iii) subject to subparagraph (E), in the case  
19 of any other employee welfare benefit plan which is  
20 a multiple employer welfare arrangement and which  
21 provides medical care (within the meaning of section  
22 733(a)(2)), any law of any State which regulates in-  
23 surance may apply.”.

24           (4) Section 514(d) of such Act (29 U.S.C.  
25 1144(d)) is amended—

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

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

6 “(2) Nothing in any other provision of law enacted  
7 on or after the date of the enactment of this paragraph  
8 shall be construed to alter, amend, modify, invalidate, im-  
9 pair, or supersede any provision of this title, except by  
10 specific cross-reference to the affected section.”.

11 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
12 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
13 the following new sentence: “Such term also includes a  
14 person serving as the sponsor of an association health plan  
15 under part 8.”.

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

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

3 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
4 CATION OF SELF-INSURED ASSOCIATION HEALTH  
5 PLANS.—Not later than January 1, 2014, the Secretary  
6 of Labor shall report to the Committee on Education and  
7 the Workforce of the House of Representatives and the  
8 Committee on Health, Education, Labor, and Pensions of  
9 the Senate the effect association health plans have had,  
10 if any, on reducing the number of uninsured individuals.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

1 **SEC. 452. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
2 **PLOYER ARRANGEMENTS.**

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

6 (1) in clause (i), by inserting after “control  
7 group,” the following: “except that, in any case in  
8 which the benefit referred to in subparagraph (A)  
9 consists of medical care (as defined in section  
10 812(a)(2)), two or more trades or businesses, wheth-  
11 er or not incorporated, shall be deemed a single em-  
12 ployer for any plan year of such plan, or any fiscal  
13 year of such other arrangement, if such trades or  
14 businesses are within the same control group during  
15 such year or at any time during the preceding 1-year  
16 period,”;

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

19 “(iii)(I) in any case in which the benefit re-  
20 ferred to in subparagraph (A) consists of medical  
21 care (as defined in section 812(a)(2)), the deter-  
22 mination of whether a trade or business is under  
23 ‘common control’ with another trade or business  
24 shall be determined under regulations of the Sec-  
25 retary applying principles consistent and coextensive  
26 with the principles applied in determining whether

1 employees of two or more trades or businesses are  
2 treated as employed by a single employer under sec-  
3 tion 4001(b), except that, for purposes of this para-  
4 graph, an interest of greater than 25 percent may  
5 not be required as the minimum interest necessary  
6 for common control, or

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

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

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

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

1 **SEC. 453. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
2 **CIATION HEALTH PLANS.**

3 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
4 MISREPRESENTATIONS.—Section 501 of the Employee  
5 Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
6 is amended by adding at the end the following new sub-  
7 section:

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

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

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



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

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

9           “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-  
10 SIST ORDERS.—

11           “(1) IN GENERAL.—Subject to paragraph (2),  
12           upon application by the Secretary showing the oper-  
13           ation, promotion, or marketing of an association  
14           health plan (or similar arrangement providing bene-  
15           fits consisting of medical care (as defined in section  
16           733(a)(2))) that—

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

23           “(B) is an association health plan certified  
24           under part 8 and is not operating in accordance

1           with the requirements under part 8 for such  
2           certification,  
3           a district court of the United States shall enter an  
4           order requiring that the plan or arrangement cease  
5           activities.

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

10                   “(A) all benefits under it referred to in  
11                   paragraph (1) consist of health insurance cov-  
12                   erage; and

13                   “(B) with respect to each State in which  
14                   the plan or arrangement offers or provides ben-  
15                   efits, the plan or arrangement is operating in  
16                   accordance with applicable State laws that are  
17                   not superseded under section 514.

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

24           (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
25           Section 503 of such Act (29 U.S.C. 1133) is amended by

1 inserting “(a) IN GENERAL.—” before “In accordance”,  
2 and by adding at the end the following new subsection:

3 “(b) ASSOCIATION HEALTH PLANS.—The terms of  
4 each association health plan which is or has been certified  
5 under part 8 shall require the board of trustees or the  
6 named fiduciary (as applicable) to ensure that the require-  
7 ments of this section are met in connection with claims  
8 filed under the plan.”.

9 **SEC. 454. COOPERATION BETWEEN FEDERAL AND STATE**  
10 **AUTHORITIES.**

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

14 “(d) CONSULTATION WITH STATES WITH RESPECT  
15 TO ASSOCIATION HEALTH PLANS.—

16 “(1) AGREEMENTS WITH STATES.—The Sec-  
17 retary shall consult with the State recognized under  
18 paragraph (2) with respect to an association health  
19 plan regarding the exercise of—

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

23 “(B) the Secretary’s authority to certify  
24 association health plans under part 8 in accord-

1           ance with regulations of the Secretary applica-  
2           ble to certification under part 8.

3           “(2) RECOGNITION OF PRIMARY DOMICILE  
4           STATE.—In carrying out paragraph (1), the Sec-  
5           retary shall ensure that only one State will be recog-  
6           nized, with respect to any particular association  
7           health plan, as the State with which consultation is  
8           required. In carrying out this paragraph—

9                   “(A) in the case of a plan which provides  
10                  health insurance coverage (as defined in section  
11                  812(a)(3)), such State shall be the State with  
12                  which filing and approval of a policy type of-  
13                  fered by the plan was initially obtained, and

14                   “(B) in any other case, the Secretary shall  
15                  take into account the places of residence of the  
16                  participants and beneficiaries under the plan  
17                  and the State in which the trust is main-  
18                  tained.”.

19 **SEC. 455. EFFECTIVE DATE AND TRANSITIONAL AND**  
20 **OTHER RULES.**

21           (a) EFFECTIVE DATE.—The amendments made by  
22 this subtitle shall take effect 1 year after the date of the  
23 enactment of this Act. The Secretary of Labor shall first  
24 issue all regulations necessary to carry out the amend-

1 ments made by this subtitle within 1 year after the date  
2 of the enactment of this Act.

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

5 (1) IN GENERAL.—In any case in which, as of  
6 the date of the enactment of this Act, an arrange-  
7 ment is maintained in a State for the purpose of  
8 providing benefits consisting of medical care for the  
9 employees and beneficiaries of its participating em-  
10 ployers, at least 200 participating employers make  
11 contributions to such arrangement, such arrange-  
12 ment has been in existence for at least 10 years, and  
13 such arrangement is licensed under the laws of one  
14 or more States to provide such benefits to its par-  
15 ticipating employers, upon the filing with the appli-  
16 cable authority (as defined in section 812(a)(5) of  
17 the Employee Retirement Income Security Act of  
18 1974 (as amended by this subtitle)) by the arrange-  
19 ment of an application for certification of the ar-  
20 rangement under part 8 of subtitle B of title I of  
21 such Act—

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

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

5 (C) the requirements of section 803(b) of  
6 such Act shall be deemed met, if the arrange-  
7 ment is operated by a board of directors  
8 which—

9 (i) is elected by the participating em-  
10 ployers, with each employer having one  
11 vote; and

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

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

18 (E) the arrangement may be certified by  
19 any applicable authority with respect to its op-  
20 erations in any State only if it operates in such  
21 State on the date of certification.

22 The provisions of this subsection shall cease to apply  
23 with respect to any such arrangement at such time  
24 after the date of the enactment of this Act as the

1 applicable requirements of this subsection are not  
2 met with respect to such arrangement.

3 (2) DEFINITIONS.—For purposes of this sub-  
4 section, the terms “group health plan”, “medical  
5 care”, and “participating employer” shall have the  
6 meanings provided in section 812 of the Employee  
7 Retirement Income Security Act of 1974, except  
8 that the reference in paragraph (7) of such section  
9 to an “association health plan” shall be deemed a  
10 reference to an arrangement referred to in this sub-  
11 section.

## 12 **TITLE V—REFORMING MEDICAL** 13 **LIABILITY LAW**

### 14 **SEC. 501. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

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

- 23 (1) upon proof of fraud;
- 24 (2) intentional concealment; or

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

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

14   **SEC. 502. COMPENSATING PATIENT INJURY.**

15           (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL  
16   ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any  
17   health care lawsuit, nothing in this subtitle shall limit a  
18   claimant's recovery of the full amount of the available eco-  
19   nomic damages, notwithstanding the limitation in sub-  
20   section (b).

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



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

3 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC  
4 DAMAGES.—For purposes of applying the limitation in  
5 subsection (b), future noneconomic damages shall not be  
6 discounted to present value. The jury shall not be in-  
7 formed about the maximum award for noneconomic dam-  
8 ages. An award for noneconomic damages in excess of  
9 \$250,000 shall be reduced either before the entry of judg-  
10 ment, or by amendment of the judgment after entry of  
11 judgment, and such reduction shall be made before ac-  
12 counting for any other reduction in damages required by  
13 law. If separate awards are rendered for past and future  
14 noneconomic damages and the combined awards exceed  
15 \$250,000, the future noneconomic damages shall be re-  
16 duced first.

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

1 this section, the trier of fact shall determine the propor-  
2 tion of responsibility of each party for the claimant's  
3 harm.

4 **SEC. 503. MAXIMIZING PATIENT RECOVERY.**

5 (a) COURT SUPERVISION OF SHARE OF DAMAGES  
6 ACTUALLY PAID TO CLAIMANTS.—In any health care law-  
7 suit, the court shall supervise the arrangements for pay-  
8 ment of damages to protect against conflicts of interest  
9 that may have the effect of reducing the amount of dam-  
10 ages awarded that are actually paid to claimants. In par-  
11 ticular, in any health care lawsuit in which the attorney  
12 for a party claims a financial stake in the outcome by vir-  
13 tue of a contingent fee, the court shall have the power  
14 to restrict the payment of a claimant's damage recovery  
15 to such attorney, and to redirect such damages to the  
16 claimant based upon the interests of justice and principles  
17 of equity. In no event shall the total of all contingent fees  
18 for representing all claimants in a health care lawsuit ex-  
19 ceed the following limits:

20 (1) Forty percent of the first \$50,000 recovered  
21 by the claimant(s).

22 (2) Thirty-three and one-third percent of the  
23 next \$50,000 recovered by the claimant(s).

24 (3) Twenty-five percent of the next \$500,000  
25 recovered by the claimant(s).

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

3           (b) APPLICABILITY.—The limitations in this section  
4 shall apply whether the recovery is by judgment, settle-  
5 ment, mediation, arbitration, or any other form of alter-  
6 native dispute resolution. In a health care lawsuit involv-  
7 ing a minor or incompetent person, a court retains the  
8 authority to authorize or approve a fee that is less than  
9 the maximum permitted under this section. The require-  
10 ment for court supervision in the first two sentences of  
11 subsection (a) applies only in civil actions.

12 **SEC. 504. PUNITIVE DAMAGES.**

13           (a) IN GENERAL.—Punitive damages may, if other-  
14 wise permitted by applicable State or Federal law, be  
15 awarded against any person in a health care lawsuit only  
16 if it is proven by clear and convincing evidence that such  
17 person acted with malicious intent to injure the claimant,  
18 or that such person deliberately failed to avoid unneces-  
19 sary injury that such person knew the claimant was sub-  
20 stantially certain to suffer. In any health care lawsuit  
21 where no judgment for compensatory damages is rendered  
22 against such person, no punitive damages may be awarded  
23 with respect to the claim in such lawsuit. No demand for  
24 punitive damages shall be included in a health care lawsuit  
25 as initially filed. A court may allow a claimant to file an

1 amended pleading for punitive damages only upon a mo-  
2 tion by the claimant and after a finding by the court, upon  
3 review of supporting and opposing affidavits or after a  
4 hearing, after weighing the evidence, that the claimant has  
5 established by a substantial probability that the claimant  
6 will prevail on the claim for punitive damages. At the re-  
7 quest of any party in a health care lawsuit, the trier of  
8 fact shall consider in a separate proceeding—

9           (1) whether punitive damages are to be award-  
10        ed and the amount of such award; and

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

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

18       (b) DETERMINING AMOUNT OF PUNITIVE DAM-  
19 AGES.—

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

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

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

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

5 (D) the number of products sold or med-  
6 ical procedures rendered for compensation, as  
7 the case may be, by such party, of the kind  
8 causing the harm complained of by the claim-  
9 ant;

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

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

16 (2) MAXIMUM AWARD.—The amount of punitive  
17 damages, if awarded, in a health care lawsuit may  
18 be as much as \$250,000 or as much as two times  
19 the amount of economic damages awarded, which-  
20 ever is greater. The jury shall not be informed of  
21 this limitation.

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

24 (1) IN GENERAL.—

1 (A) No punitive damages may be awarded  
2 against the manufacturer or distributor of a  
3 medical product, or a supplier of any compo-  
4 nent or raw material of such medical product,  
5 based on a claim that such product caused the  
6 claimant's harm where—

7 (i)(I) such medical product was sub-  
8 ject to premarket approval, clearance, or li-  
9 censure by the Food and Drug Administra-  
10 tion with respect to the safety of the for-  
11 mulation or performance of the aspect of  
12 such medical product which caused the  
13 claimant's harm or the adequacy of the  
14 packaging or labeling of such medical  
15 product; and

16 (II) such medical product was so ap-  
17 proved, cleared, or licensed; or

18 (ii) such medical product is generally  
19 recognized among qualified experts as safe  
20 and effective pursuant to conditions estab-  
21 lished by the Food and Drug Administra-  
22 tion and applicable Food and Drug Admin-  
23 istration regulations, including without  
24 limitation those related to packaging and  
25 labeling, unless the Food and Drug Admin-

1           istration has determined that such medical  
2           product was not manufactured or distrib-  
3           uted in substantial compliance with appli-  
4           cable Food and Drug Administration stat-  
5           utes and regulations.

6           (B) RULE OF CONSTRUCTION.—Subpara-  
7           graph (A) may not be construed as establishing  
8           the obligation of the Food and Drug Adminis-  
9           tration to demonstrate affirmatively that a  
10          manufacturer, distributor, or supplier referred  
11          to in such subparagraph meets any of the con-  
12          ditions described in such subparagraph.

13          (2) LIABILITY OF HEALTH CARE PROVIDERS.—  
14          A health care provider who prescribes, or who dis-  
15          penses pursuant to a prescription, a medical product  
16          approved, licensed, or cleared by the Food and Drug  
17          Administration shall not be named as a party to a  
18          product liability lawsuit involving such product and  
19          shall not be liable to a claimant in a class action  
20          lawsuit against the manufacturer, distributor, or  
21          seller of such product. Nothing in this paragraph  
22          prevents a court from consolidating cases involving  
23          health care providers and cases involving products li-  
24          ability claims against the manufacturer, distributor,  
25          or product seller of such medical product.

1           (3) PACKAGING.—In a health care lawsuit for  
2           harm which is alleged to relate to the adequacy of  
3           the packaging or labeling of a drug which is required  
4           to have tamper-resistant packaging under regula-  
5           tions of the Secretary of Health and Human Serv-  
6           ices (including labeling regulations related to such  
7           packaging), the manufacturer or product seller of  
8           the drug shall not be held liable for punitive dam-  
9           ages unless such packaging or labeling is found by  
10          the trier of fact by clear and convincing evidence to  
11          be substantially out of compliance with such regula-  
12          tions.

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

15                (A) a person, before or after premarket ap-  
16                proval, clearance, or licensure of such medical  
17                product, knowingly misrepresented to or with-  
18                held from the Food and Drug Administration  
19                information that is required to be submitted  
20                under the Federal Food, Drug, and Cosmetic  
21                Act (21 U.S.C. 301 et seq.) or section 351 of  
22                the Public Health Service Act (42 U.S.C. 262)  
23                that is material and is causally related to the  
24                harm which the claimant allegedly suffered; or



1 (B) a person made an illegal payment to  
2 an official of the Food and Drug Administra-  
3 tion for the purpose of either securing or main-  
4 taining approval, clearance, or licensure of such  
5 medical product.

6 **SEC. 505. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**  
7 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**  
8 **SUITS.**

9 (a) IN GENERAL.—In any health care lawsuit, if an  
10 award of future damages, without reduction to present  
11 value, equaling or exceeding \$50,000 is made against a  
12 party with sufficient insurance or other assets to fund a  
13 periodic payment of such a judgment, the court shall, at  
14 the request of any party, enter a judgment ordering that  
15 the future damages be paid by periodic payments, in ac-  
16 cordance with the Uniform Periodic Payment of Judg-  
17 ments Act promulgated by the National Conference of  
18 Commissioners on Uniform State Laws.

19 (b) APPLICABILITY.—This section applies to all ac-  
20 tions which have not been first set for trial or retrial be-  
21 fore the effective date of this Act.

22 **SEC. 506. DEFINITIONS.**

23 In this subtitle:

24 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
25 TEM; ADR.—The term “alternative dispute resolution

1 system” or “ADR” means a system that provides  
2 for the resolution of health care lawsuits in a man-  
3 ner other than through a civil action brought in a  
4 State or Federal court.

5 (2) CLAIMANT.—The term “claimant” means  
6 any person who brings a health care lawsuit, includ-  
7 ing a person who asserts or claims a right to legal  
8 or equitable contribution, indemnity, or subrogation,  
9 arising out of a health care liability claim or action,  
10 and any person on whose behalf such a claim is as-  
11 serted or such an action is brought, whether de-  
12 ceased, incompetent, or a minor.

13 (3) COMPENSATORY DAMAGES.—The term  
14 “compensatory damages” means objectively  
15 verifiable monetary losses incurred as a result of the  
16 provision of, use of, or payment for (or failure to  
17 provide, use, or pay for) health care services or med-  
18 ical products, such as past and future medical ex-  
19 penses, loss of past and future earnings, cost of ob-  
20 taining domestic services, loss of employment, and  
21 loss of business or employment opportunities, dam-  
22 ages for physical and emotional pain, suffering, in-  
23 convenience, physical impairment, mental anguish,  
24 disfigurement, loss of enjoyment of life, loss of soci-  
25 ety and companionship, loss of consortium (other

1 than loss of domestic service), hedonic damages, in-  
2 jury to reputation, and all other nonpecuniary losses  
3 of any kind or nature. The term “compensatory  
4 damages” includes economic damages and non-  
5 economic damages, as such terms are defined in this  
6 section.

7 (4) CONTINGENT FEE.—The term “contingent  
8 fee” includes all compensation to any person or per-  
9 sons which is payable only if a recovery is effected  
10 on behalf of one or more claimants.

11 (5) ECONOMIC DAMAGES.—The term “economic  
12 damages” means objectively verifiable monetary  
13 losses incurred as a result of the provision of, use  
14 of, or payment for (or failure to provide, use, or pay  
15 for) health care services or medical products, such as  
16 past and future medical expenses, loss of past and  
17 future earnings, cost of obtaining domestic services,  
18 loss of employment, and loss of business or employ-  
19 ment opportunities.

20 (6) HEALTH CARE LAWSUIT.—The term  
21 “health care lawsuit” means any health care liability  
22 claim concerning the provision of health care goods  
23 or services or any medical product affecting inter-  
24 state commerce, or any health care liability action  
25 concerning the provision of health care goods or

1 services or any medical product affecting interstate  
2 commerce, brought in a State or Federal court or  
3 pursuant to an alternative dispute resolution system,  
4 against a health care provider, a health care organi-  
5 zation, or the manufacturer, distributor, supplier,  
6 marketer, promoter, or seller of a medical product,  
7 regardless of the theory of liability on which the  
8 claim is based, or the number of claimants, plain-  
9 tiffs, defendants, or other parties, or the number of  
10 claims or causes of action, in which the claimant al-  
11 leges a health care liability claim. Such term does  
12 not include a claim or action which is based on  
13 criminal liability; which seeks civil fines or penalties  
14 paid to Federal, State, or local government; or which  
15 is grounded in antitrust. Except for the purposes of  
16 sections 501, 502(d), 503, and 505(a), such term  
17 does not include a claim or action which is based on  
18 intentional denial of medical treatment that a pa-  
19 tient is otherwise qualified to receive with the intent  
20 of causing or hastening the patient's death against  
21 the wishes of the patient, or, if the patient is incom-  
22 petent, against the wishes of the individual or indi-  
23 viduals authorized to make health care decisions on  
24 behalf of the patient.

1           (7) HEALTH CARE LIABILITY ACTION.—The  
2 term “health care liability action” means a civil ac-  
3 tion brought in a State or Federal court or pursuant  
4 to an alternative dispute resolution system, against  
5 a health care provider, a health care organization, or  
6 the manufacturer, distributor, supplier, marketer,  
7 promoter, or seller of a medical product, regardless  
8 of the theory of liability on which the claim is based,  
9 or the number of plaintiffs, defendants, or other par-  
10 ties, or the number of causes of action, in which the  
11 claimant alleges a health care liability claim.

12           (8) HEALTH CARE LIABILITY CLAIM.—The  
13 term “health care liability claim” means a demand  
14 by any person, whether or not pursuant to ADR,  
15 against a health care provider, health care organiza-  
16 tion, or the manufacturer, distributor, supplier, mar-  
17 keter, promoter, or seller of a medical product, in-  
18 cluding, but not limited to, third-party claims, cross-  
19 claims, counter-claims, or contribution claims, which  
20 are based upon the provision of, use of, or payment  
21 for (or the failure to provide, use, or pay for) health  
22 care services or medical products, regardless of the  
23 theory of liability on which the claim is based, or the  
24 number of plaintiffs, defendants, or other parties, or  
25 the number of causes of action.

1           (9) HEALTH CARE ORGANIZATION.—The term  
2           “health care organization” means any person or en-  
3           tity which is obligated to provide or pay for health  
4           benefits under any health plan, including any person  
5           or entity acting under a contract or arrangement  
6           with a health care organization to provide or admin-  
7           ister any health benefit.

8           (10) HEALTH CARE PROVIDER.—The term  
9           “health care provider” means any person or entity  
10          required by State or Federal laws or regulations to  
11          be licensed, registered, or certified to provide health  
12          care services, and being either so licensed, reg-  
13          istered, or certified, or exempted from such require-  
14          ment by other statute or regulation.

15          (11) HEALTH CARE GOODS OR SERVICES.—The  
16          term “health care goods or services” means any  
17          goods or services provided by a health care organiza-  
18          tion, provider, or by any individual working under  
19          the supervision of a health care provider, that relates  
20          to the diagnosis, prevention, or treatment of any  
21          human disease or impairment, or the assessment or  
22          care of the health of human beings.

23          (12) MALICIOUS INTENT TO INJURE.—The  
24          term “malicious intent to injure” means inten-  
25          tionally causing or attempting to cause physical in-

1 jury other than providing health care goods or serv-  
2 ices.

3 (13) MEDICAL PRODUCT.—The term “medical  
4 product” means a drug, device, or biological product  
5 intended for humans, and the terms “drug”, “de-  
6 vice”, and “biological product” have the meanings  
7 given such terms in sections 201(g)(1) and 201(h)  
8 of the Federal Food, Drug and Cosmetic Act (21  
9 U.S.C. 321(g)(1) and (h)) and section 351(a) of the  
10 Public Health Service Act (42 U.S.C. 262(a)), re-  
11 spectively, including any component or raw material  
12 used therein, but excluding health care services.

13 (14) NONECONOMIC DAMAGES.—The term  
14 “noneconomic damages” means damages for phys-  
15 ical and emotional pain, suffering, inconvenience,  
16 physical impairment, mental anguish, disfigurement,  
17 loss of enjoyment of life, loss of society and compan-  
18 ionship, loss of consortium (other than loss of do-  
19 mestic service), hedonic damages, injury to reputa-  
20 tion, and all other nonpecuniary losses of any kind  
21 or nature.

22 (15) PUNITIVE DAMAGES.—The term “punitive  
23 damages” means damages awarded, for the purpose  
24 of punishment or deterrence, and not solely for com-  
25 pensatory purposes, against a health care provider,

1 health care organization, or a manufacturer, dis-  
2 tributor, or supplier of a medical product. Punitive  
3 damages are neither economic nor noneconomic  
4 damages.

5 (16) RECOVERY.—The term “recovery” means  
6 the net sum recovered after deducting any disburse-  
7 ments or costs incurred in connection with prosecu-  
8 tion or settlement of the claim, including all costs  
9 paid or advanced by any person. Costs of health care  
10 incurred by the plaintiff and the attorneys’ office  
11 overhead costs or charges for legal services are not  
12 deductible disbursements or costs for such purpose.

13 (17) STATE.—The term “State” means each of  
14 the several States, the District of Columbia, the  
15 Commonwealth of Puerto Rico, the Virgin Islands,  
16 Guam, American Samoa, the Northern Mariana Is-  
17 lands, the Trust Territory of the Pacific Islands, and  
18 any other territory or possession of the United  
19 States, or any political subdivision thereof.

20 **SEC. 507. EFFECT ON OTHER LAWS.**

21 (a) VACCINE INJURY.—

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



1 (A) this subtitle does not affect the appli-  
2 cation of the rule of law to such an action; and

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

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

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

17 **SEC. 508. STATE FLEXIBILITY AND PROTECTION OF**  
18 **STATES' RIGHTS.**

19 (a) HEALTH CARE LAWSUITS.—The provisions gov-  
20 erning health care lawsuits set forth in this subtitle pre-  
21 empt, subject to subsections (b) and (c), State law to the  
22 extent that State law prevents the application of any pro-  
23 visions of law established by or under this subtitle. The  
24 provisions governing health care lawsuits set forth in this

1 subtitle supersede chapter 171 of title 28, United States  
2 Code, to the extent that such chapter—

3           (1) provides for a greater amount of damages  
4           or contingent fees, a longer period in which a health  
5           care lawsuit may be commenced, or a reduced appli-  
6           cability or scope of periodic payment of future dam-  
7           ages, than provided in this subtitle; or

8           (2) prohibits the introduction of evidence re-  
9           garding collateral source benefits, or mandates or  
10          permits subrogation or a lien on collateral source  
11          benefits.

12          (b) PROTECTION OF STATES' RIGHTS AND OTHER  
13 LAWS.—(1) Any issue that is not governed by any provi-  
14 sion of law established by or under this subtitle (including  
15 State standards of negligence) shall be governed by other-  
16 wise applicable State or Federal law.

17          (2) This subtitle shall not preempt or supersede any  
18 State or Federal law that imposes greater procedural or  
19 substantive protections for health care providers and  
20 health care organizations from liability, loss, or damages  
21 than those provided by this subtitle or create a cause of  
22 action.

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

1           (1) any State law (whether effective before, on,  
2           or after the date of the enactment of this Act) that  
3           specifies a particular monetary amount of compen-  
4           satory or punitive damages (or the total amount of  
5           damages) that may be awarded in a health care law-  
6           suit, regardless of whether such monetary amount is  
7           greater or lesser than is provided for under this sub-  
8           title, notwithstanding section 4(a); or

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

12 **SEC. 509. APPLICABILITY; EFFECTIVE DATE.**

13          This subtitle shall apply to any health care lawsuit  
14          brought in a Federal or State court, or subject to an alter-  
15          native dispute resolution system, that is initiated on or  
16          after the date of the enactment of this Act, except that  
17          any health care lawsuit arising from an injury occurring  
18          prior to the date of the enactment of this Act shall be  
19          governed by the applicable statute of limitations provisions  
20          in effect at the time the injury occurred.

21 **TITLE VI—RESPECTING HUMAN**  
22 **LIFE**

23 **SEC. 601. SPECIAL RULES REGARDING ABORTION.**

24          (a) PROHIBITION ON ABORTION MANDATES.—Noth-  
25          ing in this Act (or any amendment made by this Act) shall

1 be construed to require any health plan (including any  
2 high risk pool described in section 311) to provide cov-  
3 erage of or access to abortion services or to allow the Sec-  
4 retary of the Treasury, the Secretary of Labor, the Sec-  
5 retary of Health and Human Services, or any other Fed-  
6 eral or non-Federal person or entity in implementing this  
7 Act (or amendment) to require coverage of, or access to,  
8 abortion services.

9 (b) LIMITATION ON ABORTION FUNDING.—

10 (1) IN GENERAL.—No funds authorized or ap-  
11 propriated by this Act (or an amendment made by  
12 this Act) may be used to pay for any abortion or to  
13 cover any part of the costs of any health plan that  
14 includes coverage of abortion (including a high risk  
15 pool described in section 311), except—

16 (A) if the pregnancy is the result of an act  
17 of rape or incest; or

18 (B) in the case where a pregnant female  
19 suffers from a physical disorder, physical in-  
20 jury, or physical illness that would, as certified  
21 by a physician, place the female in danger of  
22 death unless an abortion is performed, includ-  
23 ing a life-endangering physical condition caused  
24 by or arising from the pregnancy itself.

1           (2) OPTION TO PURCHASE SEPARATE COV-  
2 ERAGE OR PLAN.—Nothing in this subsection shall  
3 be construed as prohibiting any non-Federal entity  
4 (including an individual or a State or local govern-  
5 ment) from purchasing separate coverage for abor-  
6 tions for which funding is prohibited under this sub-  
7 section, or a health plan that includes such abor-  
8 tions, so long as such coverage or plan is paid for  
9 entirely using only funds not authorized or appro-  
10 priated by this Act.

11           (3) OPTION TO OFFER COVERAGE OR PLAN.—  
12 Nothing in this subsection shall restrict any non-  
13 Federal health insurance issuer offering a health  
14 plan from offering separate coverage for abortions  
15 for which funding is prohibited under this sub-  
16 section, or a health plan that includes such abor-  
17 tions, so long as—

18                   (A) premiums for such separate coverage  
19 or plan are paid for entirely with funds not au-  
20 thorized or appropriated by this Act; and

21                   (B) administrative costs and all services  
22 offered through such coverage or plan are paid  
23 for using only premiums collected for such cov-  
24 erage or plan.

1           (4) ADMINISTRATIVE EXPENSES.—No funds  
2 authorized or appropriated by this Act shall be avail-  
3 able to pay for administrative expenses in connection  
4 with any health plan (including an Association  
5 Health Plan that has entered into trusteeship) which  
6 provides any benefits or coverage for abortions ex-  
7 cept where the life of the mother would be endan-  
8 gered if the fetus were carried to term, or the preg-  
9 nancy is the result of an act of rape or incest.

10       (c) NO PREEMPTION OF STATE LAWS.—Nothing in  
11 this Act (or an amendment made by this Act) shall be  
12 construed to preempt or otherwise have any effect on  
13 State laws protecting conscience rights, restricting or pro-  
14 hibiting abortion or coverage or funding of abortion (in-  
15 cluding State laws opting out of abortion coverage pursu-  
16 ant to section 1303 of the Patient Protection and Afford-  
17 able Care Act, Public Law 111–148), as in effect before  
18 the date of the enactment of this Act, or establishing pro-  
19 cedural requirements on abortions, including parental no-  
20 tification or consent for the performance of an abortion  
21 on a minor.

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