

113TH CONGRESS  
1ST SESSION

# H. R. 3622

To repeal the Patient Protection and Affordable Care Act and provide for comprehensive health reform, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 22, 2013

Mr. DUFFY 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, Rules, and Appropriations, 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 provide for comprehensive health reform, and for other purposes.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Patient Centered Healthcare Savings Act of 2013”.

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

Sec. 1. Short title; table of contents.

#### TITLE I—REPEALING OF PPACA

Sec. 101. Repeal of the health care reform package.

#### TITLE II—MEDICAL LIABILITY REFORM

Sec. 201. Findings and purpose.

Sec. 202. Encouraging speedy resolution of claims.

Sec. 203. Compensating patient injury.

Sec. 204. Maximizing patient recovery.

Sec. 205. Punitive damages.

Sec. 206. Authorization of payment of future damages to claimants in  
HEALTH care lawsuits.

Sec. 207. Definitions.

Sec. 208. Effect on other laws.

Sec. 209. State flexibility and protection of States' rights.

Sec. 210. Applicability; effective date.

#### TITLE III—ALLOWING PEOPLE TO PURCHASE HEALTH INSURANCE ACROSS STATE LINES

Sec. 301. Specification of constitutional authority for enactment of law.

Sec. 302. Findings.

Sec. 303. Cooperative governing of individual health insurance coverage.

Sec. 304. Severability.

#### TITLE IV—INCREASING TRANSPARENCY AND COMPETITION IN HEALTHCARE

Sec. 401. Expanding availability of Medicare data.

#### TITLE V—EXPANDING THE EFFECTIVENESS OF HEALTH SAVINGS ACCOUNTS

Sec. 501. Amendment of 1986 Code.

##### Subtitle A—Provisions Relating to Tax-Preferred Health Accounts

Sec. 511. Allow both spouses to make catch-up contributions to the same HSA  
account.

Sec. 512. Provisions relating to Medicare.

Sec. 513. Individuals eligible for veterans benefits for a service-connected dis-  
ability.

Sec. 514. Individuals eligible for Indian Health Service assistance.

Sec. 515. Individuals eligible for TRICARE coverage.

Sec. 516. Health FSA carryforwards.

Sec. 517. FSA and HRA interaction with HSAs.

Sec. 518. Allowance of distributions for prescription and over-the-counter medi-  
cines and drugs.

Sec. 519. Purchase of health insurance from HSA account.

Sec. 520. Special rule for certain medical expenses incurred before establish-  
ment of account.

Sec. 521. Preventive care prescription drug clarification.

Sec. 522. Equivalent bankruptcy protections for health savings accounts as re-  
irement funds.

Sec. 523. Administrative error correction before due date of return.

Sec. 524. Reauthorization of medicaid health opportunity accounts.

Subtitle B—Other Provisions

Sec. 531. Certain exercise equipment and physical fitness programs treated as medical care.

Sec. 532. Certain nutritional and dietary supplements to be treated as medical care.

Sec. 533. Certain provider fees to be treated as medical care.

TITLE VI—COVERING PEOPLE WITH PRE-EXISTING CONDITIONS, REMOVING ANNUAL AND LIFETIME COVERAGE CAPS, AND EXPANDING ACCESS TO CARE

Subtitle A—Making Health Care Coverage Affordable for Every American

CHAPTER 1—ENSURING COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

Sec. 601. Establish universal access programs to improve high risk pools and reinsurance markets.

Sec. 602. Elimination of certain requirements for guaranteed availability in individual market.

Sec. 603. No annual or lifetime spending caps.

Sec. 604. Preventing unjust cancellation of insurance coverage.

CHAPTER 2—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

Sec. 611. State innovation programs.

Sec. 612. Health plan finders.

Sec. 613. Administrative simplification.

Subtitle B—Improving Access to Health Care

CHAPTER 1—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Sec. 620. Short title.

Sec. 621. Rules governing association health plans.

Sec. 622. Clarification of treatment of single employer arrangements.

Sec. 623. Enforcement provisions relating to association health plans.

Sec. 624. Cooperation between Federal and State authorities.

Sec. 625. Effective date and transitional and other rules.

CHAPTER 2—TARGETED EFFORTS TO EXPAND ACCESS

Sec. 631. Extending coverage of dependents.

Sec. 632. Allowing auto-enrollment for employer sponsored coverage.

TITLE VII—STOPPING MEDICARE, WASTE, FRAUD, AND ABUSE AND INCREASING PENALTIES FOR ABUSERS

Sec. 701. Increased civil money penalties and criminal fines for Medicare fraud and abuse.

Sec. 702. Increased sentences for felonies involving Medicare fraud and abuse.

Sec. 703. Other DME supplier anti-fraud and abuse provisions.

Sec. 704. Retention of certain fraud and abuse provisions.

Sec. 705. Ensuring timely enforcement of Medicare secondary payer requirements in liability cases.

## 1 **TITLE I—REPEALING OF PPACA**

### 2 **SEC. 101. REPEAL OF THE HEALTH CARE REFORM PACK-** 3 **AGE.**

4 (a) PPACA.—The Patient Protection and Affordable  
5 Care Act is repealed, and the provisions of law amended  
6 or repealed by such Act are restored or revived as if such  
7 Act had not been enacted.

8 (b) HCERA.—Title I and subtitle B of title II of the  
9 Health Care and Education Reconciliation Act of 2010 are  
10 repealed, and the provisions of law amended or repealed  
11 by such title or subtitle are restored or revived as if such  
12 title or subtitle had not been enacted.

## 13 **TITLE II—MEDICAL LIABILITY** 14 **REFORM**

### 15 **SEC. 201. FINDINGS AND PURPOSE.**

16 (a) FINDINGS.—

17 (1) EFFECT ON HEALTH CARE ACCESS AND  
18 COSTS.—Congress finds that our current civil justice  
19 system is adversely affecting patient access to health  
20 care services, better patient care, and cost-efficient  
21 health care, in that the health care liability system  
22 is a costly and ineffective mechanism for resolving  
23 claims of health care liability and compensating in-  
24 jured patients, and is a deterrent to the sharing of

1 information among health care professionals which  
2 impedes efforts to improve patient safety and quality  
3 of care.

4 (2) EFFECT ON FEDERAL SPENDING.—Con-  
5 gress finds that the health care liability litigation  
6 systems existing throughout the United States have  
7 a significant effect on the amount, distribution, and  
8 use of Federal funds because of—

9 (A) the large number of individuals who  
10 receive health care benefits under programs op-  
11 erated or financed by the Federal Government;

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

16 (C) the large number of health care pro-  
17 viders who provide items or services for which  
18 the Federal Government makes payments.

19 (b) PURPOSE.—It is the purpose of this title to imple-  
20 ment reasonable, comprehensive, and effective health care  
21 liability reforms designed to—

22 (1) improve the availability of health care serv-  
23 ices in cases in which health care liability actions  
24 have been shown to be a factor in the decreased  
25 availability of services;

1           (2) reduce the incidence of “defensive medi-  
2           cine” and lower the cost of health care liability in-  
3           surance, all of which contribute to the escalation of  
4           health care costs;

5           (3) ensure that persons with meritorious health  
6           care injury claims receive fair and adequate com-  
7           pensation, including reasonable noneconomic dam-  
8           ages;

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

14          (5) provide an increased sharing of information  
15          in the health care system which will reduce unin-  
16          tended injury and improve patient care.

17 **SEC. 202. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

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

- 1 (1) upon proof of fraud;
- 2 (2) intentional concealment; or
- 3 (3) the presence of a foreign body, which has no
- 4 therapeutic or diagnostic purpose or effect, in the
- 5 person of the injured person.

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

16 **SEC. 203. COMPENSATING PATIENT INJURY.**

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

22 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any  
23 health care lawsuit, the amount of noneconomic damages,  
24 if available, may be as much as \$250,000, regardless of  
25 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. 204. 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. 205. 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. 206. 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. 207. DEFINITIONS.**

23 In this title:

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.

16 (7) HEALTH CARE LIABILITY ACTION.—The  
17 term “health care liability action” means a civil ac-  
18 tion brought in a State or Federal court or pursuant  
19 to an alternative dispute resolution system, against  
20 a health care provider, a health care organization, or  
21 the manufacturer, distributor, supplier, marketer,  
22 promoter, or seller of a medical product, regardless  
23 of the theory of liability on which the claim is based,  
24 or the number of plaintiffs, defendants, or other par-

1 ties, or the number of causes of action, in which the  
2 claimant alleges a health care liability claim.

3 (8) HEALTH CARE LIABILITY CLAIM.—The  
4 term “health care liability claim” means a demand  
5 by any person, whether or not pursuant to ADR,  
6 against a health care provider, health care organiza-  
7 tion, or the manufacturer, distributor, supplier, mar-  
8 keter, promoter, or seller of a medical product, in-  
9 cluding, but not limited to, third-party claims, cross-  
10 claims, counter-claims, or contribution claims, which  
11 are based upon the provision of, use of, or payment  
12 for (or the failure to provide, use, or pay for) health  
13 care services or medical products, regardless of the  
14 theory of liability on which the claim is based, or the  
15 number of plaintiffs, defendants, or other parties, or  
16 the number of causes of action.

17 (9) HEALTH CARE ORGANIZATION.—The term  
18 “health care organization” means any person or en-  
19 tity which is obligated to provide or pay for health  
20 benefits under any health plan, including any person  
21 or entity acting under a contract or arrangement  
22 with a health care organization to provide or admin-  
23 ister any health benefit.

24 (10) HEALTH CARE PROVIDER.—The term  
25 “health care provider” means any person or entity

1 required by State or Federal laws or regulations to  
2 be licensed, registered, or certified to provide health  
3 care services, and being either so licensed, reg-  
4 istered, or certified, or exempted from such require-  
5 ment by other statute or regulation.

6 (11) HEALTH CARE GOODS OR SERVICES.—The  
7 term “health care goods or services” means any  
8 goods or services provided by a health care organiza-  
9 tion, provider, or by any individual working under  
10 the supervision of a health care provider, that relates  
11 to the diagnosis, prevention, or treatment of any  
12 human disease or impairment, or the assessment or  
13 care of the health of human beings.

14 (12) MALICIOUS INTENT TO INJURE.—The  
15 term “malicious intent to injure” means inten-  
16 tionally causing or attempting to cause physical in-  
17 jury other than providing health care goods or serv-  
18 ices.

19 (13) MEDICAL PRODUCT.—The term “medical  
20 product” means a drug, device, or biological product  
21 intended for humans, and the terms “drug”, “de-  
22 vice”, and “biological product” have the meanings  
23 given such terms in sections 201(g)(1) and 201(h)  
24 of the Federal Food, Drug, and Cosmetic Act (21  
25 U.S.C. 321(g)(1) and (h)) and section 351(a) of the

1 Public Health Service Act (42 U.S.C. 262(a)), re-  
2 spectively, including any component or raw material  
3 used therein, but excluding health care services.

4 (14) NONECONOMIC DAMAGES.—The term  
5 “noneconomic damages” means damages for phys-  
6 ical and emotional pain, suffering, inconvenience,  
7 physical impairment, mental anguish, disfigurement,  
8 loss of enjoyment of life, loss of society and compan-  
9 ionship, loss of consortium (other than loss of do-  
10 mestic service), hedonic damages, injury to reputa-  
11 tion, and all other nonpecuniary losses of any kind  
12 or nature.

13 (15) PUNITIVE DAMAGES.—The term “punitive  
14 damages” means damages awarded, for the purpose  
15 of punishment or deterrence, and not solely for com-  
16 pensatory purposes, against a health care provider,  
17 health care organization, or a manufacturer, dis-  
18 tributor, or supplier of a medical product. Punitive  
19 damages are neither economic nor noneconomic  
20 damages.

21 (16) RECOVERY.—The term “recovery” means  
22 the net sum recovered after deducting any disburse-  
23 ments or costs incurred in connection with prosecu-  
24 tion or settlement of the claim, including all costs  
25 paid or advanced by any person. Costs of health care

1 incurred by the plaintiff and the attorneys' office  
2 overhead costs or charges for legal services are not  
3 deductible disbursements or costs for such purpose.

4 (17) STATE.—The term “State” means each of  
5 the several States, the District of Columbia, the  
6 Commonwealth of Puerto Rico, the Virgin Islands,  
7 Guam, American Samoa, the Northern Mariana Is-  
8 lands, the Trust Territory of the Pacific Islands, and  
9 any other territory or possession of the United  
10 States, or any political subdivision thereof.

11 **SEC. 208. EFFECT ON OTHER LAWS.**

12 (a) VACCINE INJURY.—

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

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

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

22 (2) If there is an aspect of a civil action  
23 brought for a vaccine-related injury or death to  
24 which a Federal rule of law under title XXI of the  
25 Public Health Service Act does not apply, then this

1 title or otherwise applicable law (as determined  
2 under this title) will apply to such aspect of such ac-  
3 tion.

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

8 **SEC. 209. STATE FLEXIBILITY AND PROTECTION OF**  
9 **STATES' RIGHTS.**

10 (a) HEALTH CARE LAWSUITS.—The provisions gov-  
11 erning health care lawsuits set forth in this title preempt,  
12 subject to subsections (b) and (c), State law to the extent  
13 that State law prevents the application of any provisions  
14 of law established by or under this title. The provisions  
15 governing health care lawsuits set forth in this title super-  
16 sede chapter 171 of title 28, United States Code, to the  
17 extent that such chapter—

18 (1) provides for a greater amount of damages  
19 or contingent fees, a longer period in which a health  
20 care lawsuit may be commenced, or a reduced appli-  
21 cability or scope of periodic payment of future dam-  
22 ages, than provided in this title; or

23 (2) prohibits the introduction of evidence re-  
24 garding collateral source benefits, or mandates or



1       permits subrogation or a lien on collateral source  
2       benefits.

3       (b) PROTECTION OF STATES' RIGHTS AND OTHER  
4 LAWS.—(1) Any issue that is not governed by any provi-  
5 sion of law established by or under this title (including  
6 State standards of negligence) shall be governed by other-  
7 wise applicable State or Federal law.

8       (2) This title shall not preempt or supersede any  
9 State or Federal law that imposes greater procedural or  
10 substantive protections for health care providers and  
11 health care organizations from liability, loss, or damages  
12 than those provided by this title or create a cause of ac-  
13 tion.

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

16           (1) any State law (whether effective before, on,  
17           or after the date of the enactment of this Act) that  
18           specifies a particular monetary amount of compen-  
19           satory or punitive damages (or the total amount of  
20           damages) that may be awarded in a health care law-  
21           suit, regardless of whether such monetary amount is  
22           greater or lesser than is provided for under this title,  
23           notwithstanding section 204(a); or

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

4 **SEC. 210. APPLICABILITY; EFFECTIVE DATE.**

5           This title shall apply to any health care lawsuit  
6           brought in a Federal or State court, or subject to an alter-  
7           native dispute resolution system, that is initiated on or  
8           after the date of the enactment of this Act, except that  
9           any health care lawsuit arising from an injury occurring  
10          prior to the date of the enactment of this Act shall be  
11          governed by the applicable statute of limitations provisions  
12          in effect at the time the injury occurred.

13 **TITLE III—ALLOWING PEOPLE**  
14 **TO PURCHASE HEALTH IN-**  
15 **SURANCE ACROSS STATE**  
16 **LINES**

17 **SEC. 301. SPECIFICATION OF CONSTITUTIONAL AUTHORITY**  
18 **FOR ENACTMENT OF LAW.**

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

22 **SEC. 302. FINDINGS.**

23          Congress finds the following:

24                 (1) The application of numerous and significant  
25          variations in State law and the implementation of

1 the Patient Protection and Affordable Care Act im-  
2 pacts the ability of insurers to offer, and individuals  
3 to obtain, affordable individual health insurance cov-  
4 erage, thereby impeding commerce in individual  
5 health insurance coverage.

6 (2) Mandates for health care coverage estab-  
7 lished by title I of the Patient Protection and Af-  
8 fordable Care Act will significantly elevate health in-  
9 surance costs beyond State and Federal ability to  
10 pay.

11 (3) Individual health insurance coverage is in-  
12 creasingly offered through the Internet, other elec-  
13 tronic means, and by mail, all of which are inher-  
14 ently part of interstate commerce.

15 (4) In response to these issues, it is appropriate  
16 to encourage increased efficiency in the offering of  
17 individual health insurance coverage through a col-  
18 laborative approach by the States in regulating this  
19 coverage.

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

1 **SEC. 303. COOPERATIVE GOVERNING OF INDIVIDUAL**  
2 **HEALTH INSURANCE COVERAGE.**

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

6 **“PART D—COOPERATIVE GOVERNING OF**  
7 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

8 **“SEC. 2795. DEFINITIONS.**

9 “In this part:

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

25 “(2) SECONDARY STATE.—The term ‘secondary  
26 State’ means, with respect to individual health insur-

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

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

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

18               “(5) APPLICABLE STATE AUTHORITY.—The  
19       term ‘applicable State authority’ means, with respect  
20       to a health insurance issuer in a State, the State in-  
21       surance commissioner or official or officials des-  
22       ignated by the State to enforce the requirements of  
23       this title for the State with respect to the issuer.

24               “(6) HAZARDOUS FINANCIAL CONDITION.—The  
25       term ‘hazardous financial condition’ means that,

1 based on its present or reasonably anticipated finan-  
2 cial condition, a health insurance issuer is unlikely  
3 to be able—

4 “(A) to meet obligations to policyholders  
5 with respect to known claims and reasonably  
6 anticipated claims; or

7 “(B) to pay other obligations in the normal  
8 course of business.

9 “(7) COVERED LAWS.—

10 “(A) IN GENERAL.—The term ‘covered  
11 laws’ means the laws, rules, regulations, agree-  
12 ments, and orders governing the insurance busi-  
13 ness pertaining to—

14 “(i) individual health insurance cov-  
15 erage issued by a health insurance issuer;

16 “(ii) the offer, sale, rating (including  
17 medical underwriting), renewal, and  
18 issuance of individual health insurance cov-  
19 erage to an individual;

20 “(iii) the provision to an individual in  
21 relation to individual health insurance cov-  
22 erage of health care and insurance related  
23 services;

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

1 erage of management, operations, and in-  
2 vestment activities of a health insurance  
3 issuer; and

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

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

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

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

1           “(A) Knowingly misrepresenting to claim-  
2           ants and insured individuals relevant facts or  
3           policy provisions relating to coverage at issue.

4           “(B) Failing to acknowledge with reason-  
5           able promptness pertinent communications with  
6           respect to claims arising under policies.

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

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

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

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

19          “(G) A pattern or practice of compelling  
20          insured individuals or their beneficiaries to in-  
21          stitute suits to recover amounts due under its  
22          policies by offering substantially less than the  
23          amounts ultimately recovered in suits brought  
24          by them.



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

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

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

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

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

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

1 will be presented to or by an insurer, a rein-  
2 surer, broker or its agent, false information as  
3 part of, in support of or concerning a fact ma-  
4 terial to one or more of the following:

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

8 “(ii) The rating of an insurance policy  
9 or reinsurance contract.

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

13 “(iv) Premiums paid on an insurance  
14 policy or reinsurance contract.

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

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

21 “(vii) The financial condition of an in-  
22 surer or reinsurer.

23 “(viii) The formation, acquisition,  
24 merger, reconsolidation, dissolution or  
25 withdrawal from one or more lines of in-

1 insurance or reinsurance in all or part of a  
2 State by an insurer or reinsurer.

3 “(ix) The issuance of written evidence  
4 of insurance.

5 “(x) The reinstatement of an insur-  
6 ance policy.

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

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

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

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

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

1 and in any secondary State, but only if the coverage and  
2 issuer comply with the conditions of this section with re-  
3 spect to the offering of coverage in any secondary State.

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

13 “(1) make unlawful, or regulate, directly or in-  
14 directly, the operation of the health insurance issuer  
15 operating in the secondary State, except that any  
16 secondary State may require such an issuer—

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

22 “(B) to register with and designate the  
23 State insurance commissioner as its agent solely  
24 for the purpose of receiving service of legal doc-  
25 uments or process;

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

6                   “(i) the State insurance commissioner  
7                   of the primary State has not done an ex-  
8                   amination within the period recommended  
9                   by the National Association of Insurance  
10                  Commissioners; and

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

17           “(D) to comply with a lawful order  
18           issued—

19                   “(i) in a delinquency proceeding com-  
20                   menced by the State insurance commis-  
21                   sioner if there has been a finding of finan-  
22                   cial impairment under subparagraph (C);  
23                   or

24                   “(ii) in a voluntary dissolution pro-  
25                   ceeding;

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

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

11           “(G) to comply with any State law regard-  
12 ing fraud and abuse (as defined in section  
13 2795(10)), except that if the State seeks an in-  
14 junction regarding the conduct described in this  
15 subparagraph, such injunction must be obtained  
16 from a court of competent jurisdiction;

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

20           “(I) to comply with the applicable require-  
21 ments for independent review under section  
22 2798 with respect to coverage offered in the  
23 State;

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

1 an insurance agent or broker residing in that Sec-  
 2 ondary State; or

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

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

16 “NOTICE

17 “This policy is issued by \_\_\_\_\_ and is gov-  
 18 erned by the laws and regulations of the State of  
 19 \_\_\_\_\_, and it has met all the laws of that State as  
 20 determined by that State’s Department of Insurance. This  
 21 policy may be less expensive than others because it is not  
 22 subject to all of the insurance laws and regulations of the  
 23 State of \_\_\_\_\_, including coverage of some services  
 24 or benefits mandated by the law of the State of  
 25 \_\_\_\_\_. Additionally, this policy is not subject to all

1 of the consumer protection laws or restrictions on rate  
2 changes of the State of \_\_\_\_\_. As with all insurance  
3 products, before purchasing this policy, you should care-  
4 fully review the policy and determine what health care  
5 services the policy covers and what benefits it provides,  
6 including any exclusions, limitations, or conditions for  
7 such services or benefits.’.

8 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
9 AND PREMIUM INCREASES.—

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

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

20 “(B) increase the premiums assessed the  
21 individual for such coverage based on a health  
22 status-related factor or change of a health sta-  
23 tus-related factor or the past or prospective  
24 claim experience of the insured individual.



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

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

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

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

15           “(i) are disclosed to the consumer in  
16 the insurance contract;

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

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

22           “(D) from reinstating lapsed coverage; or

23           “(E) from retroactively adjusting the rates  
24 charged an insured individual if the initial rates

1           were set based on material misrepresentation by  
2           the individual at the time of issue.

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

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

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

22           “(1) to the insurance commissioner of each  
23 State in which it intends to offer such coverage, be-  
24 fore it may offer individual health insurance cov-  
25 erage in such State—

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

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

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

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

19                  “(A) a member of the American Academy  
20                  of Actuaries; or

21                  “(B) a qualified loss reserve specialist.

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

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

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

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

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

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

23           “(2) COURTS OF COMPETENT JURISDICTION.—

24          If a State seeks an injunction regarding the conduct  
25 described in paragraphs (1) and (2) of subsection

1 (h), such injunction must be obtained from a Fed-  
2 eral or State court of competent jurisdiction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11           “(3) INDEPENDENCE.—

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7   **“SEC. 2799. ENFORCEMENT.**

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

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

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

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

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

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

7 (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

6 **SEC. 304. SEVERABILITY.**

7           If any provision of this title or the application of such  
8           provision to any person or circumstance is held to be un-  
9           constitutional, the remainder of this title and the applica-  
10          tion of the provisions of such to any other person or cir-  
11          cumstance shall not be affected.

12 **TITLE IV—INCREASING TRANSPARENCY AND COMPETITION**  
13 **IN HEALTHCARE**

15 **SEC. 401. EXPANDING AVAILABILITY OF MEDICARE DATA.**

16          (a) EXPANDING USES OF MEDICARE DATA BY  
17          QUALIFIED ENTITIES.—

18           (1) IN GENERAL.—To the extent consistent  
19           with applicable information, privacy, security, and  
20           disclosure laws, beginning with 2014, notwith-  
21           standing paragraph (4)(B) of section 1874(e) of the  
22           Social Security Act (42 U.S.C. 1395kk(e)) and the  
23           second sentence of paragraph (4)(D) of such section,  
24           a qualified entity may use data received by such en-  
25           tity under such section, and information derived

1 from the evaluation described in such paragraph  
2 (4)(D), for additional non-public analyses (as deter-  
3 mined appropriate by the Secretary of Health and  
4 Human Services) or provide or sell such data to reg-  
5 istered or authorized users and subscribers, includ-  
6 ing to providers of services and suppliers, for non-  
7 public use (including for the purposes of assisting  
8 providers of services and suppliers to develop and  
9 participate in quality and patient care improvement  
10 activities, including developing new models of care).

11 (2) DEFINITIONS.—In this section:

12 (A) The term “qualified entity” has the  
13 meaning given such term in section 1874(e)(2)  
14 of the Social Security Act (42 U.S.C.  
15 1395kk(e)).

16 (B) The terms “supplier” and “provider of  
17 services” have the meanings given such terms  
18 in subsections (d) and (u), respectively, of sec-  
19 tion 1861 of the Social Security Act (42 U.S.C.  
20 1395x).

21 (b) ACCESS TO MEDICARE DATA TO PROVIDERS OF  
22 SERVICES AND SUPPLIERS TO FACILITATE DEVELOP-  
23 MENT OF ALTERNATIVE PAYMENT MODELS AND TO  
24 QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE  
25 QUALITY IMPROVEMENT.—Consistent with applicable



1 laws and regulations with respect to privacy and other rel-  
2 evant matters, the Secretary shall provide Medicare claims  
3 data (in a form and manner determined to be appropriate)  
4 to—

5           (1) qualified entities, that may share with pro-  
6 viders of services and suppliers that are registered or  
7 authorized users or subscribers, for non-public use  
8 including to facilitate the development of new models  
9 of care (including development of Alternate Payment  
10 Models under section 1848A of the Social Security  
11 Act, models for small group specialty practices, and  
12 care coordination models); and

13           (2) qualified clinical data registries under sec-  
14 tion 1848(m)(3)(E) of the Social Security Act (42  
15 U.S.C. 1395w-4(m)(3)(E)) for purposes of linking  
16 such data with clinical outcomes data and per-  
17 forming and disseminating risk-adjusted, scientif-  
18 ically valid analysis and research to support quality  
19 improvement or patient safety, provided that any  
20 public reporting of identifiable provider data shall  
21 only be conducted with prior consent of such pro-  
22 vider.

1 **TITLE V—EXPANDING THE EF-**  
 2 **ECTIVENESS OF HEALTH**  
 3 **SAVINGS ACCOUNTS**

4 **SEC. 501. AMENDMENT OF 1986 CODE.**

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

11 **Subtitle A—Provisions Relating to**  
 12 **Tax-Preferred Health Accounts**

13 **SEC. 511. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**  
 14 **TRIBUTIONS TO THE SAME HSA ACCOUNT.**

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

18 “(C) SPECIAL RULE WHERE BOTH  
 19 SPOUSES ARE ELIGIBLE INDIVIDUALS WITH 1  
 20 ACCOUNT.—If—

21 “(i) an individual and the individual’s  
 22 spouse have both attained age 55 before  
 23 the close of the taxable year, and

1                   “(ii) the spouse is not an account ben-  
2                   eficiary of a health savings account as of  
3                   the close of such year,  
4                   the additional contribution amount shall be 200  
5                   percent of the amount otherwise determined  
6                   under subparagraph (B).”.

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

10 **SEC. 512. PROVISIONS RELATING TO MEDICARE.**

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

20           (b) MEDICARE BENEFICIARIES PARTICIPATING IN  
21 MEDICARE ADVANTAGE MSA MAY CONTRIBUTE THEIR  
22 OWN MONEY TO THEIR MSA.—Subsection (b) of section  
23 138 is amended by striking paragraph (2) and by redesignig-  
24 nating paragraphs (3) and (4) as paragraphs (2) and (3),  
25 respectively.

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

4 **SEC. 513. INDIVIDUALS ELIGIBLE FOR VETERANS BENE-**  
5 **FITS FOR A SERVICE-CONNECTED DIS-**  
6 **ABILITY.**

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

10 “(C) SPECIAL RULE FOR INDIVIDUALS ELI-  
11 GIBLE FOR CERTAIN VETERANS BENEFITS.—  
12 For purposes of subparagraph (A)(ii), an indi-  
13 vidual shall not be treated as covered under a  
14 health plan described in such subparagraph  
15 merely because the individual receives periodic  
16 hospital care or medical services for a service-  
17 connected disability under any law administered  
18 by the Secretary of Veterans Affairs but only if  
19 the individual is not eligible to receive such care  
20 or services for any condition other than a serv-  
21 ice-connected disability.”.

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. 514. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH**  
2 **SERVICE ASSISTANCE.**

3 (a) IN GENERAL.—Paragraph (1) of section 223(c),  
4 as amended by section 612, is amended by adding at the  
5 end the following new subparagraph:

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

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

19 **SEC. 515. INDIVIDUALS ELIGIBLE FOR TRICARE COVERAGE.**

20 (a) IN GENERAL.—Paragraph (1) of section 223(c),  
21 as amended by sections 613 and 614, is amended by add-  
22 ing at the end the following new subparagraph:

23 “(E) SPECIAL RULE FOR INDIVIDUALS EL-  
24 IGIBLE FOR ASSISTANCE UNDER TRICARE.—For  
25 purposes of subparagraph (A)(ii), an individual  
26 shall not be treated as covered under a health

1           plan described in such subparagraph merely be-  
2           cause the individual is eligible to receive hos-  
3           pital care, medical services, or prescription  
4           drugs under TRICARE Extra or TRICARE  
5           Standard and such individual is not enrolled in  
6           TRICARE Prime.”.

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

10   **SEC. 516. HEALTH FSA CARRYFORWARDS.**

11           (a) IN GENERAL.—Section 125 is amended by redес-  
12           ignating subsections (i) and (j) as subsections (j) and (k),  
13           respectively, and by inserting after subsection (h) the fol-  
14           lowing new subsection:

15           “(i) SPECIAL RULES APPLICABLE TO HEALTH  
16           FLEXIBLE SPENDING ARRANGEMENTS.—

17                   “(1) IN GENERAL.—For purposes of this title,  
18           a plan or other arrangement shall not fail to be  
19           treated as a health flexible spending or similar ar-  
20           rangement solely because under the plan or arrange-  
21           ment a participant is permitted access to any unused  
22           balance in the participant’s accounts under such  
23           plan or arrangement in the manner provided under  
24           paragraph (2).

1           “(2) CARRYFORWARD OF UNUSED BENEFITS IN  
2 HEALTH ARRANGEMENTS.—

3           “(A) IN GENERAL.—A plan or arrange-  
4 ment may permit a participant in a health flexi-  
5 ble spending arrangement to elect to carry for-  
6 ward any aggregate unused balances in the par-  
7 ticipant’s accounts under such arrangement as  
8 of the close of any year to the succeeding year.  
9 Such carryforward shall be treated as having  
10 occurred within 30 days of the close of the year.

11           “(B)           DOLLAR           LIMIT           ON  
12 CARRYFORWARDS.—

13           “(i) IN GENERAL.—The amount which  
14 a participant may elect to carry forward  
15 under subparagraph (A) from any year  
16 shall not exceed \$500. For purposes of this  
17 paragraph, all plans and arrangements  
18 maintained by an employer or any related  
19 person shall be treated as 1 plan.

20           “(ii) COST-OF-LIVING ADJUSTMENT.—  
21 In the case of any taxable year beginning  
22 in a calendar year after 2013, the \$500  
23 amount under clause (i) shall be increased  
24 by an amount equal to—

25                           “(I) \$500, multiplied by

1                   “(II) the cost-of-living adjust-  
2                   ment determined under section 1(f)(3)  
3                   for such calendar year, determined by  
4                   substituting ‘2012’ for ‘1992’ in sub-  
5                   paragraph (B) thereof.

6                   If any dollar amount as increased under  
7                   this clause is not a multiple of \$100, such  
8                   amount shall be rounded to the next lowest  
9                   multiple of \$100.

10                  “(C) EXCLUSION FROM GROSS INCOME.—  
11                  No amount shall be required to be included in  
12                  gross income under this chapter by reason of  
13                  any carryforward under this paragraph.

14                  “(D) COORDINATION WITH LIMITS.—The  
15                  maximum amount which may be contributed to  
16                  a health flexible spending arrangement for any  
17                  year to which an unused amount is carried  
18                  under this paragraph shall be reduced by such  
19                  amount.

20                  “(3) TERMS RELATING TO FLEXIBLE SPENDING  
21                  ARRANGEMENTS.—

22                  “(A) FLEXIBLE SPENDING ARRANGE-  
23                  MENTS.—For purposes of this subsection, a  
24                  flexible spending arrangement is a benefit pro-  
25                  gram which provides employees with coverage



1 under which specified incurred expenses may be  
2 reimbursed (subject to reimbursement maxi-  
3 mums and other reasonable conditions).

4 “(B) HEALTH ARRANGEMENTS.—The term  
5 ‘health flexible spending arrangement’ means  
6 any flexible spending arrangement (or portion  
7 thereof) which provides payments for expenses  
8 incurred for medical care (as defined in section  
9 213(d)).”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) The heading for section 125 of the Internal  
12 Revenue Code of 1986 is amended by inserting  
13 “**AND HEALTH FLEXIBLE SPENDING ARRANGE-**  
14 **MENTS**” after “**PLANS**”.

15 (2) The item relating to section 125 in the table  
16 of sections for part III of subchapter B of chapter  
17 1 of such Code is amended by inserting “and health  
18 flexible spending arrangements” after “plans”.

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall take effect on the date of the enactment  
21 of this Act.

22 **SEC. 517. FSA AND HRA INTERACTION WITH HSAS.**

23 (a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA  
24 PARTICIPANTS.—Subparagraph (B) of section 223(c)(1)  
25 is amended—

- 1           (1) by striking “and” at the end of clause (ii),  
2           (2) by striking the period at the end of clause  
3           (iii) and inserting “, and”, and  
4           (3) by inserting after clause (iii) the following  
5           new clause:

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

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

24                      “(II) coverage that, after the  
25                      qualified HSA distribution is made,

1 does not pay or reimburse any med-  
2 ical expense incurred after the quali-  
3 fied HSA distribution is made other  
4 than preventive care as defined in  
5 paragraph (2)(C),

6 “(III) coverage that, after the  
7 qualified HSA distribution is made,  
8 pays or reimburses benefits for cov-  
9 erage described in clause (ii) (but not  
10 through insurance or for long-term  
11 care services),

12 “(IV) coverage that, after the  
13 qualified HSA distribution is made,  
14 pays or reimburses benefits for per-  
15 mitted insurance or coverage de-  
16 scribed in clause (ii) (but not for long-  
17 term care services),

18 “(V) coverage that, after the  
19 qualified HSA distribution is made,  
20 pays or reimburses only those medical  
21 expenses incurred after an individual’s  
22 retirement (and no expenses incurred  
23 before retirement), or

24 “(VI) coverage that, after the  
25 qualified HSA distribution is made, is

1                   suspended, pursuant to an election  
2                   made on or before the date the indi-  
3                   vidual elects a qualified HSA distribu-  
4                   tion or, if later, on the date of the in-  
5                   dividual enrolls in a high deductible  
6                   health plan, that does not pay or re-  
7                   imburse, at any time, any medical ex-  
8                   pense incurred during the suspension  
9                   period except as defined in the pre-  
10                  ceding subclauses of this clause.”.

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

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

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

23                   “(E) EXCEPTION FOR QUALIFIED HSA DIS-  
24                   TRIBUTIONS.—Subparagraph (A) shall not  
25                   apply to the extent that there is an amount re-

1           maintaining in a health flexible spending account at  
2           the end of a plan year that an individual elects  
3           to contribute to a health savings account pursu-  
4           ant to a qualified HSA distribution (as defined  
5           in section 106(e)(2)).”.

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

9           “(2) QUALIFIED HSA DISTRIBUTION.—

10           “(A) IN GENERAL.—The term ‘qualified  
11 HSA distribution’ means a distribution from a  
12 health flexible spending arrangement or health  
13 reimbursement arrangement to the extent that  
14 such distribution does not exceed the lesser  
15 of—

16           “(i) the balance in such arrangement  
17 as of the date of such distribution, or

18           “(ii) the amount determined under  
19 subparagraph (B).

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

22           “(B) DOLLAR LIMITATIONS.—

23           “(i) DISTRIBUTIONS FROM A HEALTH  
24 FLEXIBLE SPENDING ARRANGEMENT.—A  
25 qualified HSA distribution from a health

1 flexible spending arrangement shall not ex-  
2 ceed the applicable amount.

3 “(ii) DISTRIBUTIONS FROM A HEALTH  
4 REIMBURSEMENT ARRANGEMENT.—A  
5 qualified HSA distribution from a health  
6 reimbursement arrangement shall not ex-  
7 ceed—

8 “(I) the applicable amount di-  
9 vided by 12, multiplied by

10 “(II) the number of months dur-  
11 ing which the individual is a partici-  
12 pant in the health reimbursement ar-  
13 rangement.

14 “(iii) APPLICABLE AMOUNT.—For  
15 purposes of this subparagraph, the applica-  
16 ble amount is—

17 “(I) \$2,250 in the case of an eli-  
18 gible individual who has self-only cov-  
19 erage under a high deductible health  
20 plan at the time of such distribution,  
21 and

22 “(II) \$4,500 in the case of an eli-  
23 gible individual who has family cov-  
24 erage under a high deductible health

1                    plan at the time of such distribu-  
2                    tion.”.

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

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

9            (2) by striking subparagraph (A) of paragraph  
10 (3), as so redesignated, and redesignating subpara-  
11 graphs (B) and (C) of such paragraph as subpara-  
12 graphs (A) and (B) thereof, respectively.

13            (f) LIMITED PURPOSE FSAS AND HRAS.—Sub-  
14 section (e) of section 106, as amended by this section, is  
15 amended by adding at the end the following new para-  
16 graph:

17            “(5) LIMITED PURPOSE FSAS AND HRAS.—A  
18 plan shall not fail to be a health flexible spending  
19 arrangement or health reimbursement arrangement  
20 under this section or section 105 merely because the  
21 plan converts coverage for individuals who enroll in  
22 a high deductible health plan described in section  
23 223(c)(2) to coverage described in section  
24 223(c)(1)(B)(iv). Coverage for such individuals may  
25 be converted as of the date of enrollment in the high

1 deductible health plan, without regard to the period  
2 of coverage under the health flexible spending ar-  
3 rangement or health reimbursement arrangement,  
4 and without requiring any change in coverage to in-  
5 dividuals who do not enroll in a high deductible  
6 health plan.”.

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

11 “(6) COST-OF-LIVING ADJUSTMENT.—

12 “(A) IN GENERAL.—In the case of any  
13 taxable year beginning after December 31,  
14 2013, each of the dollar amounts in paragraph  
15 (2)(B)(iii) shall be increased by an amount  
16 equal to such dollar amount, multiplied by the  
17 cost-of-living adjustment determined under sec-  
18 tion 1(f)(3) for the calendar year in which such  
19 taxable year begins by substituting ‘calendar  
20 year 2012’ for ‘calendar year 1992’ in subpara-  
21 graph (B) thereof.

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



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

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

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

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

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

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

1 **SEC. 518. ALLOWANCE OF DISTRIBUTIONS FOR PRESCRIP-**  
2 **TION AND OVER-THE-COUNTER MEDICINES**  
3 **AND DRUGS.**

4 (a) REFERENCE TO REPEAL OF DISTRIBUTIONS FOR  
5 MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG  
6 OR INSULIN.—Section 101 of this Act provides for the re-  
7 peal of section 9003 of the Patient Protection and Afford-  
8 able Care Act (Public Law 111–148) and the amendments  
9 made by such section. The Internal Revenue Code of 1986  
10 shall be applied as if such section 9003 and amendments  
11 had never been enacted.

12 (b) ALLOWANCE OF DISTRIBUTIONS FOR ALL MEDI-  
13 CINES AND DRUGS.—

14 (1) HSAS.—Subparagraph (A) of section  
15 223(d)(2) is amended by adding at the end the fol-  
16 lowing: “Such term shall include an amount paid for  
17 any prescription or over-the-counter medicine or  
18 drug.”.

19 (2) ARCHER MSAS.—Subparagraph (A) of sec-  
20 tion 220(d)(2) is amended by adding at the end the  
21 following: “Such term shall include an amount paid  
22 for any prescription or over-the-counter medicine or  
23 drug.”.

24 (3) HEALTH FLEXIBLE SPENDING ARRANGE-  
25 MENTS AND HEALTH REIMBURSEMENT ARRANGE-

1       MENTS.—Section 106 is amended by adding at the  
2       end the following new subsection:

3       “(f) REIMBURSEMENTS FOR ALL MEDICINES AND  
4 DRUGS.—For purposes of this section and section 105,  
5 reimbursement for expenses incurred for any prescription  
6 or over-the-counter medicine or drug shall be treated as  
7 a reimbursement for medical expenses.”.

8           (4) EFFECTIVE DATES.—

9           (A) DISTRIBUTIONS FROM SAVINGS AC-  
10       COUNTS.—The amendments made by para-  
11       graphs (1) and (2) shall apply to amounts paid  
12       with respect to taxable years beginning after  
13       December 31, 2013.

14           (B) REIMBURSEMENTS.—The amendment  
15       made by paragraph (3) shall apply to expenses  
16       incurred with respect to taxable years beginning  
17       after December 31, 2013.

18 **SEC. 519. PURCHASE OF HEALTH INSURANCE FROM HSA**  
19 **ACCOUNT.**

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

22       “(2) QUALIFIED MEDICAL EXPENSES.—

23           “(A) IN GENERAL.—The term ‘qualified  
24       medical expenses’ means, with respect to an ac-  
25       count beneficiary, amounts paid by such bene-

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

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

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

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

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

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

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

24                   “(v) any health insurance under title  
25                   XVIII of the Social Security Act, other

1           than a Medicare supplemental policy (as  
2           defined in section 1882 of such Act).”.

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

7 **SEC. 520. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**  
8                   **INCURRED BEFORE ESTABLISHMENT OF AC-**  
9                   **COUNT.**

10          (a) **IN GENERAL.**—Paragraph (2) of section 223(d),  
11 as amended by section 619, is amended by adding at the  
12 end the following new subparagraph:

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

20                           “(i) during either—

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

24                                   “(II) the preceding taxable year  
25 in the case of a health savings ac-

1 count established after the taxable  
2 year in which such expense was in-  
3 curred but before the time prescribed  
4 by law for filing the return for such  
5 taxable year (not including extensions  
6 thereof), and

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

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

16 **SEC. 521. PREVENTIVE CARE PRESCRIPTION DRUG CLARI-**  
17 **FICATION.**

18 (a) CLARIFY USE OF DRUGS IN PREVENTIVE  
19 CARE.—Subparagraph (C) of section 223(c)(2) is amend-  
20 ed by adding at the end the following: “Preventive care  
21 shall include prescription and over-the-counter drugs and  
22 medicines which have the primary purpose of preventing  
23 the onset of, further deterioration from, or complications  
24 associated with chronic conditions, illnesses, or diseases.”.

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

4 **SEC. 522. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**  
5 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**  
6 **MENT FUNDS.**

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

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

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

20 **SEC. 523. ADMINISTRATIVE ERROR CORRECTION BEFORE**  
21 **DUE DATE OF RETURN.**

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

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

7                   “(i) such distribution is received by  
8                   the individual on or before the last day  
9                   prescribed by law (including extensions of  
10                  time) for filing such individual’s return for  
11                  such taxable year, and

12                   “(ii) such distribution is accompanied  
13                   by the amount of net income attributable  
14                   to such contribution.

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

18           (b) EFFECTIVE DATE.—The amendment made by  
19           this section shall take effect on the date of the enactment  
20           of this Act.

21           **SEC. 524. REAUTHORIZATION OF MEDICAID HEALTH OP-**  
22   **PORTUNITY ACCOUNTS.**

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

25                   (1) in subsection (a)—



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

3 “(2) INITIAL DEMONSTRATION.—The dem-  
4 onstration program under this section shall begin 90  
5 days after the date of the enactment of this para-  
6 graph. The Secretary shall approve States to con-  
7 duct demonstration programs under this section for  
8 a 5-year period, with each State demonstration pro-  
9 gram covering 1 or more geographic areas specified  
10 by the State. With respect to a State, after the ini-  
11 tial 5-year period of any demonstration program  
12 conducted under this section by the State, unless the  
13 Secretary finds, taking into account cost-effective-  
14 ness and quality of care, that the State demonstra-  
15 tion program has been unsuccessful, the demonstra-  
16 tion program may be extended or made permanent  
17 in the State.”; and

18 (B) in paragraph (3), in the matter pre-  
19 ceding subparagraph (A)—

20 (i) by striking “not”; and

21 (ii) by striking “unless” and inserting  
22 “if”;

23 (2) in subsection (b)—

24 (A) in paragraph (3), by inserting “clauses

25 (i) through (vii), (viii) (without regard to the

1 amendment made by section 2004(c)(2) of Pub-  
2 lic Law 111–148), (x), or (xi) of” after “de-  
3 scribed in”; and

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

6 (3) in subsection (c)—

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

8 (B) by redesignating paragraphs (5)  
9 through (8) as paragraphs (3) through (6), re-  
10 spectively; and

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

15 (4) in subsection (d)—

16 (A) in paragraph (2), by striking subpara-  
17 graph (E); and

18 (B) in paragraph (3)—

19 (i) in subparagraph (A)(ii), by strik-  
20 ing “Subject to subparagraph (B)(ii), in”  
21 and inserting “In”; and

22 (ii) by striking subparagraph (B) and  
23 inserting the following:

24 “(B) MAINTENANCE OF HEALTH OPPOR-  
25 TUNITY ACCOUNT AFTER BECOMING INELI-

1           GIBLE FOR PUBLIC BENEFIT.—Notwithstanding  
2           any other provision of law, if an account holder  
3           of a health opportunity account becomes ineli-  
4           gible for benefits under this title because of an  
5           increase in income or assets—

6                     “(i) no additional contribution shall be  
7                     made into the account under paragraph  
8                     (2)(A)(i); and

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

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

1           **Subtitle B—Other Provisions**

2   **SEC. 531. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL**  
3                   **FITNESS PROGRAMS TREATED AS MEDICAL**  
4                   **CARE.**

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

8                   “(12) EXERCISE EQUIPMENT AND PHYSICAL  
9 FITNESS PROGRAMS.—

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

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

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

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

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

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. 532. CERTAIN NUTRITIONAL AND DIETARY SUPPLE-**  
5 **MENTS TO BE TREATED AS MEDICAL CARE.**

6 (a) IN GENERAL.—Subsection (d) of section 213, as  
7 amended by section 631, is amended by adding at the end  
8 the following new paragraph:

9 “(13) NUTRITIONAL AND DIETARY SUPPLE-  
10 MENTS.—

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

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

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

23 “(i) is permitted to bear labeling mak-  
24 ing a claim described in section 403(r)(3)

1 of the Federal Food, Drug, and Cosmetic  
2 Act, and

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

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

10 **SEC. 533. CERTAIN PROVIDER FEES TO BE TREATED AS**  
11 **MEDICAL CARE.**

12 (a) IN GENERAL.—Subsection (d) of section 213, as  
13 amended by sections 631 and 632, is amended by adding  
14 at the end the following new paragraph:

15 “(14) PERIODIC PROVIDER FEES.—The term  
16 ‘medical care’ shall include periodic fees paid to a  
17 primary physician, physician assistant, or nurse  
18 practitioner for the right to receive medical services  
19 on an as-needed basis.”.

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

1 **TITLE VI—COVERING PEOPLE**  
2 **WITH PRE-EXISTING CONDI-**  
3 **TIONS, REMOVING ANNUAL**  
4 **AND LIFETIME COVERAGE**  
5 **CAPS, AND EXPANDING AC-**  
6 **CESS TO CARE**

7 **Subtitle A—Making Health Care**  
8 **Coverage Affordable for Every**  
9 **American**

10 **CHAPTER 1—ENSURING COVERAGE FOR**  
11 **INDIVIDUALS WITH PREEXISTING**  
12 **CONDITIONS AND MULTIPLE HEALTH**  
13 **CARE NEEDS**

14 **SEC. 601. ESTABLISH UNIVERSAL ACCESS PROGRAMS TO**  
15 **IMPROVE HIGH RISK POOLS AND REINSUR-**  
16 **ANCE MARKETS.**

17 (a) STATE REQUIREMENT.—

18 (1) IN GENERAL.—Not later than January 1,  
19 2014, each State shall—

20 (A) subject to paragraph (3), operate—

21 (i) a qualified State reinsurance pro-  
22 gram described in subsection (b); or

23 (ii) qualifying State high risk pool de-  
24 scribed in subsection (c)(1); and

1 (B) subject to paragraph (3), apply to the  
2 operation of such a program from State funds  
3 an amount equivalent to the portion of State  
4 funds derived from State premium assessments  
5 (as defined by the Secretary) that are not oth-  
6 erwise used on State health care programs.

7 (2) RELATION TO CURRENT QUALIFIED HIGH  
8 RISK POOL PROGRAM.—

9 (A) STATES NOT OPERATING A QUALIFIED  
10 HIGH RISK POOL.—In the case of a State that  
11 is not operating a current section 2745 quali-  
12 fied high risk pool as of the date of the enact-  
13 ment of this Act—

14 (i) the State may only meet the re-  
15 quirement of paragraph (1) through the  
16 operation of a qualified State reinsurance  
17 program described in subsection (b); and

18 (ii) the State's operation of such a re-  
19 insurance program shall be treated, for  
20 purposes of section 2745 of the Public  
21 Health Service Act, as the operation of a  
22 qualified high risk pool described in such  
23 section.

24 (B) STATE OPERATING A QUALIFIED HIGH  
25 RISK POOL.—In the case of a State that is op-



1 erating a current section 2745 qualified high  
2 risk pool as of the date of the enactment of this  
3 Act—

4 (i) as of January 1, 2014, such a pool  
5 shall not be treated as a qualified high risk  
6 pool under section 2745 of the Public  
7 Health Service Act unless the pool is a  
8 qualifying State high risk pool described in  
9 subsection (c)(1); and

10 (ii) the State may use premium as-  
11 sessment funds described in paragraph  
12 (1)(B) to transition from operation of such  
13 a pool to operation of a qualified State re-  
14 insurance program described in subsection  
15 (b).

16 (3) APPLICATION OF FUNDS.—If the program  
17 or pool operated under paragraph (1)(A) is in strong  
18 fiscal health, as determined in accordance with  
19 standards established by the National Association of  
20 Insurance Commissioners and as approved by the  
21 State Insurance Commissioner involved, the require-  
22 ment of paragraph (1)(B) shall be deemed to be  
23 met.

24 (b) QUALIFIED STATE REINSURANCE PROGRAM.—

1           (1) IN GENERAL.—For purposes of this section,  
2           a “qualified State reinsurance program” means a  
3           program operated by a State program that provides  
4           reinsurance for health insurance coverage offered in  
5           the small group market in accordance with the  
6           model for such a program established (as of the date  
7           of the enactment of this Act).

8           (2) FORM OF PROGRAM.—A qualified State re-  
9           insurance program may provide reinsurance—

10                   (A) on a prospective or retrospective basis;

11                   and

12                   (B) on a basis that protects health insur-  
13                   ance issuers against the annual aggregate  
14                   spending of their enrollees as well as purchase  
15                   protection against individual catastrophic costs.

16           (3) SATISFACTION OF HIPAA REQUIREMENT.—

17           A qualified State reinsurance program shall be  
18           deemed, for purposes of section 2745 of the Public  
19           Health Service Act, to be a qualified high risk pool  
20           under such section.

21           (c) QUALIFYING STATE HIGH RISK POOL.—

22           (1) IN GENERAL.—A qualifying State high risk  
23           pool described in this subsection means a current  
24           section 2745 qualified high risk pool that meets the  
25           following requirements:

1           (A) The pool must provide at least two  
2 coverage options, one of which must be a high  
3 deductible health plan coupled with a health  
4 savings account.

5           (B) The pool must be funded with a stable  
6 funding source.

7           (C) The pool must eliminate any waiting  
8 lists so that all eligible residents who are seek-  
9 ing coverage through the pool should be allowed  
10 to receive coverage through the pool.

11           (D) The pool must allow for coverage of  
12 individuals who, but for the 24-month disability  
13 waiting period under section 226(b) of the So-  
14 cial Security Act, would be eligible for Medicare  
15 during the period of such waiting period.

16           (E) The pool must limit the pool premiums  
17 to no more than 150 percent of the average  
18 premium for applicable standard risk rates in  
19 that State.

20           (F) The pool must conduct education and  
21 outreach initiatives so that residents and bro-  
22 kers understand that the pool is available to eli-  
23 gible residents.

1           (G) The pool must provide coverage for  
2           preventive services and disease management for  
3           chronic diseases.

4           (2) VERIFICATION OF CITIZENSHIP OR ALIEN  
5           QUALIFICATION.—

6           (A) IN GENERAL.—Notwithstanding any  
7           other provision of law, only citizens and nation-  
8           als of the United States shall be eligible to par-  
9           ticipate in a qualifying State high risk pool that  
10          receives funds under section 2745 of the Public  
11          Health Service Act or this section.

12          (B) CONDITION OF PARTICIPATION.—As a  
13          condition of a State receiving such funds, the  
14          Secretary shall require the State to certify, to  
15          the satisfaction of the Secretary, that such  
16          State requires all applicants for coverage in the  
17          qualifying State high risk pool to provide satis-  
18          factory documentation of citizenship or nation-  
19          ality in a manner consistent with section  
20          1903(x) of the Social Security Act.

21          (C) RECORDS.—The Secretary shall keep  
22          sufficient records such that a determination of  
23          citizenship or nationality only has to be made  
24          once for any individual under this paragraph.

1           (3) RELATION TO SECTION 2745.—As of Janu-  
2           ary 1, 2014, a pool shall not qualify as qualified  
3           high risk pool under section 2745 of the Public  
4           Health Service Act unless the pool is a qualifying  
5           State high risk pool described in paragraph (1).

6           (d) WAIVERS.—In order to accommodate new and in-  
7           novative programs, the Secretary may waive such require-  
8           ments of this section for qualified State reinsurance pro-  
9           grams and for qualifying State high risk pools as the Sec-  
10          retary deems appropriate.

11          (e) FUNDING.—In addition to any other amounts ap-  
12          propriated, there is appropriated to carry out section 2745  
13          of the Public Health Service Act (including through a pro-  
14          gram or pool described in subsection (a)(1))—

15               (1) \$15,000,000,000 for the period of fiscal  
16               years 2014 through 2023; and

17               (2) an additional \$10,000,000,000 for the pe-  
18               riod of fiscal years 2019 through 2023.

19          (f) DEFINITIONS.—In this section:

20               (1) HEALTH INSURANCE COVERAGE; HEALTH  
21               INSURANCE ISSUER.—The terms “health insurance  
22               coverage” and “health insurance issuer” have the  
23               meanings given such terms in section 2791 of the  
24               Public Health Service Act.

1           (2) CURRENT SECTION 2745 QUALIFIED HIGH  
2 RISK POOL.—The term “current section 2745 quali-  
3 fied high risk pool” has the meaning given the term  
4 “qualified high risk pool” under section 2745(g) of  
5 the Public Health Service Act as in effect as of the  
6 date of the enactment of this Act.

7           (3) SECRETARY.—The term “Secretary” means  
8 the Secretary of Health and Human Services.

9           (4) STANDARD RISK RATE.—The term “stand-  
10 ard risk rate” means a rate that—

11                 (A) is determined under the State high  
12 risk pool by considering the premium rates  
13 charged by other health insurance issuers offer-  
14 ing health insurance coverage to individuals in  
15 the insurance market served;

16                 (B) is established using reasonable actu-  
17 arial techniques; and

18                 (C) reflects anticipated claims experience  
19 and expenses for the coverage involved.

20           (5) STATE.—The term “State” means any of  
21 the 50 States or the District of Columbia.

1 **SEC. 602. ELIMINATION OF CERTAIN REQUIREMENTS FOR**  
2 **GUARANTEED AVAILABILITY IN INDIVIDUAL**  
3 **MARKET.**

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

7 (1) in paragraph (1)—

8 (A) by striking “(1)(A)” and inserting  
9 “(1)”; and

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

12 (2) by adding “and” at the end of paragraph  
13 (2);

14 (3) in paragraph (3)—

15 (A) by striking “(1)(A)” and inserting  
16 “(1)”; and

17 (B) by striking the semicolon at the end  
18 and inserting a period; and

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

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

23 **SEC. 603. NO ANNUAL OR LIFETIME SPENDING CAPS.**

24 (a) IN GENERAL.—Notwithstanding any other provi-  
25 sion of law, a health insurance issuer (including an entity  
26 licensed to sell insurance with respect to a State or group

1 health plan) may not apply an annual or lifetime aggregate  
 2 spending cap on any health insurance coverage or  
 3 plan offered by such issuer. The restriction of the previous  
 4 sentence shall not apply with respect to a health insurance  
 5 coverage or plan if, as of the date of the enactment of  
 6 this Act, it would result in a significant decrease in access  
 7 to benefits under the plan or would significantly increase  
 8 premiums under the plan.

9 (b) APPLICATION.—Subsection (a) shall be enforced  
 10 as if it were included as a provision in parts A and B  
 11 of title XXVII of the Public Health Service Act (as such  
 12 title is in effect after the date of repeal of Public Law  
 13 111–148 under section 101).

14 **SEC. 604. PREVENTING UNJUST CANCELLATION OF INSUR-**  
 15 **ANCE COVERAGE.**

16 (a) CLARIFICATION REGARDING APPLICATION OF  
 17 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH  
 18 INSURANCE COVERAGE.—Section 2742 of the Public  
 19 Health Service Act (42 U.S.C. 300gg–42) is amended—

20 (1) in its heading, by inserting “, **CONTINU-**  
 21 **ATION IN FORCE, INCLUDING PROHIBITION OF**  
 22 **RESCISSION,”** after “**GUARANTEED RENEW-**  
 23 **ABILITY”**;

24 (2) in subsection (a), by inserting “, including  
 25 without rescission,” after “continue in force”; and



1 (3) in subsection (b)(2), by inserting before the  
2 period at the end the following: “, including inten-  
3 tional concealment of material facts regarding a  
4 health condition related to the condition for which  
5 coverage is being claimed”.

6 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL  
7 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1  
8 of part B of title XXVII of the Public Health Service Act  
9 is amended by adding at the end the following new section:

10 **“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
11 **THIRD PARTY REVIEW IN CERTAIN CASES.**

12 “(a) NOTICE AND REVIEW RIGHT.—If a health in-  
13 surance issuer determines to nonrenew or not continue in  
14 force, including rescind, health insurance coverage for an  
15 individual in the individual market on the basis described  
16 in section 2742(b)(2) before such nonrenewal, discontinu-  
17 ation, or rescission, may take effect the issuer shall pro-  
18 vide the individual with notice of such proposed non-  
19 renewal, discontinuation, or rescission and an opportunity  
20 for a review of such determination by an independent, ex-  
21 ternal third party under procedures specified by the Sec-  
22 retary.

23 “(b) INDEPENDENT DETERMINATION.—If the indi-  
24 vidual requests such review by an independent, external  
25 third party of a nonrenewal, discontinuation, or rescission

1 of health insurance coverage, the coverage shall remain in  
2 effect until such third party determines that the coverage  
3 may be nonrenewed, discontinued, or rescinded under sec-  
4 tion 2742(b)(2).”.

5 (c) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply after the date of the enactment  
7 of this Act with respect to health insurance coverage  
8 issued before, on, or after such date.

9 **CHAPTER 2—REDUCING HEALTH CARE**  
10 **PREMIUMS AND THE NUMBER OF UN-**  
11 **INSURED AMERICANS**

12 **SEC. 611. STATE INNOVATION PROGRAMS.**

13 (a) PROGRAMS THAT REDUCE THE COST OF  
14 HEALTH INSURANCE PREMIUMS.—

15 (1) PAYMENTS TO STATES.—

16 (A) FOR PREMIUM REDUCTIONS IN THE  
17 SMALL GROUP MARKET.—If the Secretary de-  
18 termines that a State has reduced the average  
19 per capita premium for health insurance cov-  
20 erage in the small group market in year 3, in  
21 year 6, or year 9 (as defined in subsection (c))  
22 below the premium baseline for such year (as  
23 defined paragraph (2)), the Secretary shall pay  
24 the State an amount equal to the product of—

1 (i) bonus premium percentage (as de-  
2 fined in paragraph (3)) for the State, mar-  
3 ket, and year; and

4 (ii) the maximum State premium pay-  
5 ment amount (as defined in paragraph (4))  
6 for the State, market, and year.

7 (B) FOR PREMIUM REDUCTIONS IN THE  
8 INDIVIDUAL MARKET.—If the Secretary deter-  
9 mines that a State has reduced the average per  
10 capita premium for health insurance coverage  
11 in the individual market in year 3, in year 6,  
12 or in year 9 below the premium baseline for  
13 such year, the Secretary shall pay the State an  
14 amount equal to the product of—

15 (i) bonus premium percentage for the  
16 State, market, and year; and

17 (ii) the maximum State premium pay-  
18 ment amount for the State, market, and  
19 year.

20 (2) PREMIUM BASELINE.—For purposes of this  
21 subsection, the term “premium baseline” means, for  
22 a market in a State—

23 (A) for year 1, the average per capita pre-  
24 miums for health insurance coverage in such  
25 market in the State in such year; or

1 (B) for a subsequent year, the baseline for  
2 the market in the State for the previous year  
3 under this paragraph increased by a percentage  
4 specified in accordance with a formula estab-  
5 lished by the Secretary, in consultation with the  
6 Congressional Budget Office and the Bureau of  
7 the Census, that takes into account at least the  
8 following:

9 (i) GROWTH FACTOR.—The inflation  
10 in the costs of inputs to health care serv-  
11 ices in the year.

12 (ii) HISTORIC PREMIUM GROWTH  
13 RATES.—Historic growth rates, during the  
14 10 years before year 1, of per capita pre-  
15 miums for health insurance coverage.

16 (iii) DEMOGRAPHIC CONSIDER-  
17 ATIONS.—Historic average changes in the  
18 demographics of the population covered  
19 that impact on the rate of growth of per  
20 capita health care costs.

21 (3) BONUS PREMIUM PERCENTAGE DEFINED.—

22 (A) IN GENERAL.—For purposes of this  
23 subsection, the term “bonus premium percent-  
24 age” means, for the small group market or indi-  
25 vidual market in a State for a year, such per-

1           centage as determined in accordance with the  
 2           following table based on the State’s premium  
 3           performance level (as defined in subparagraph  
 4           (B)) for such market and year:

The bonus premium percentage for a State is—	For year 3 if the premium performance level of the State is—	For year 6 if the premium performance level of the State is—	For year 9 if the premium performance level of the State is—
100 percent	at least 8.5%	at least 11%	at least 13.5%
50 percent	at least 6.38%, but less than 8.5%	at least 10.38%, but less than 11%	at least 12.88%, but less than 13.5%
25 percent	at least 4.25%, but less than 6.38%	at least 9.75%, but less than 10.38%	at least 12.25%, but less than 12.88%
0 percent	less than 4.25%	less than 9.75%	less than 12.25%.

5                           (B) PREMIUM PERFORMANCE LEVEL.—For  
 6           purposes of this subsection, the term “premium  
 7           performance level” means, for a State, market,  
 8           and year, the percentage reduction in the aver-  
 9           age per capita premiums for health insurance  
 10          coverage for the State, market, and year, as  
 11          compared to the premium baseline for such  
 12          State, market, and year.

13                       (4) MAXIMUM STATE PREMIUM PAYMENT  
 14          AMOUNT DEFINED.—For purposes of this sub-  
 15          section, the term “maximum State premium pay-  
 16          ment amount” means, for a State for the small

1 group market or the individual market for a year,  
2 the product of—

3 (A) the proportion (as determined by the  
4 Secretary), of the number of nonelderly individ-  
5 uals lawfully residing in all the States who are  
6 enrolled in health insurance coverage in the re-  
7 spective market in the year, who are residents  
8 of the State; and

9 (B) the amount available for obligation  
10 from amounts appropriated under subsection  
11 (d) for such market with respect to perform-  
12 ance in such year.

13 (5) METHODOLOGY FOR CALCULATING AVER-  
14 AGE PER CAPITA PREMIUMS.—

15 (A) ESTABLISHMENT.—The Secretary  
16 shall establish, by rule and consistent with this  
17 subsection, a methodology for computing the  
18 average per capita premiums for health insur-  
19 ance coverage for the small group market and  
20 for the individual market in each State for each  
21 year beginning with year 1.

22 (B) ADJUSTMENTS.—Under such method-  
23 ology, the Secretary shall provide for the fol-  
24 lowing adjustments (in a manner determined  
25 appropriate by the Secretary):

1 (i) EXCLUSION OF ILLEGAL ALIENS.—

2 An adjustment so as not to take into ac-  
3 count enrollees who are not lawfully  
4 present in the United States and their pre-  
5 mium costs.

6 (ii) TREATING STATE PREMIUM SUB-

7 SIDIES AS PREMIUM COSTS.—An adjust-  
8 ment so as to increase per capita pre-  
9 miums to remove the impact of premium  
10 subsidies made directly by a State to re-  
11 duce health insurance premiums.

12 (6) CONDITIONS OF PAYMENT.—As a condition  
13 of receiving a payment under paragraph (1), a State  
14 must agree to submit aggregate, non-individually  
15 identifiable data to the Secretary, in a form and  
16 manner specified by the Secretary, for use by the  
17 Secretary to determine the State's premium baseline  
18 and premium performance level for purposes of this  
19 subsection.

20 (b) PROGRAMS THAT REDUCE THE NUMBER OF UN-  
21 INSURED.—

22 (1) IN GENERAL.—If the Secretary determines  
23 that a State has reduced the percentage of unin-  
24 sured nonelderly residents in year 5, year 7, or year  
25 9, below the uninsured baseline (as defined in para-

1 graph (2)) for the State for the year, the Secretary  
2 shall pay the State an amount equal to the product  
3 of—

4 (A) bonus uninsured percentage (as de-  
5 fined in paragraph (3)) for the State and year;  
6 and

7 (B) the maximum uninsured payment  
8 amount (as defined in paragraph (4)) for the  
9 State and year.

10 (2) UNINSURED BASELINE.—

11 (A) IN GENERAL.—For purposes of this  
12 subsection, and subject to subparagraph (B),  
13 the term “uninsured baseline” means, for a  
14 State, the percentage of nonelderly residents in  
15 the State who are uninsured in year 1.

16 (B) ADJUSTMENT.—The Secretary may, at  
17 the written request of a State, adjust the unin-  
18 sured baseline for States for a year to take into  
19 account unanticipated and exceptional changes,  
20 such as an unanticipated migration, of non-  
21 elderly individuals into, or out of, States in a  
22 manner that does not reflect substantially the  
23 proportion of uninsured nonelderly residents in  
24 the States involved in year 1. Any such adjust-  
25 ment shall only be done in a manner that does



1 not result in the average of the uninsured base-  
 2 lines for nonelderly residents for all States  
 3 being changed.

4 (3) BONUS UNINSURED PERCENTAGE.—

5 (A) BONUS UNINSURED PERCENTAGE.—

6 For purposes of this subsection, the term  
 7 “bonus uninsured percentage” means, for a  
 8 State for a year, such percentage as determined  
 9 in accordance with the following table, based on  
 10 the uninsured performance level (as defined in  
 11 subparagraph (B)) for such State and year:

The bonus un- insured per- centage for a State is—	For year 5 if the uninsured per- formance level of the State is—	For year 7 if the uninsured per- formance level of the State is—	For year 9 if the uninsured per- formance level of the State is—
100 percent	at least 10%	at least 15%	at least 20%
50 percent	at least 7.5% but less than 10%	at least 13.75% but less than 15%	at least 18.75% but less than 20%
25 percent	at least 5% but less than 7.5%	at least 12.5% but less than 13.75%	at least 17.5% but less than 18.75%
0 percent	less than 5%	less than 12.5%	less than 17.5%.

12 (B) UNINSURED PERFORMANCE LEVEL.—

13 For purposes of this subsection, the term “un-  
 14 insured performance level” means, for a State  
 15 for a year, the reduction (expressed as a per-  
 16 centage) in the percentage of uninsured non-  
 17 elderly residents in such State in the year as

1 compared to the uninsured baseline for such  
2 State for such year.

3 (4) MAXIMUM STATE UNINSURED PAYMENT  
4 AMOUNT DEFINED.—For purposes of this sub-  
5 section, the term “maximum State uninsured pay-  
6 ment amount” means, for a State for a year, the  
7 product of—

8 (A) the proportion (as determined by the  
9 Secretary), of the number of uninsured non-  
10 elderly individuals lawfully residing in all the  
11 States in the year, who are residents of the  
12 State; and

13 (B) the amount available for obligation  
14 under this subsection from amounts appro-  
15 priated under subsection (d) with respect to  
16 performance in such year.

17 (5) METHODOLOGY FOR COMPUTING THE PER-  
18 CENTAGE OF UNINSURED NONELDERLY RESIDENTS  
19 IN A STATE.—

20 (A) ESTABLISHMENT.—The Secretary  
21 shall establish, by rule and consistent with this  
22 subsection, a methodology for computing the  
23 percentage of nonelderly residents in a State  
24 who are uninsured in each year beginning with  
25 year 1.

1 (B) RULES.—

2 (i) TREATMENT OF UNINSURED.—

3 Such methodology shall treat as uninsured  
4 those residents who do not have health in-  
5 surance coverage or other creditable cov-  
6 erage (as defined in section 9801(c)(1) of  
7 the Internal Revenue Code of 1986), ex-  
8 cept that such methodology shall rely upon  
9 data on the nonelderly and uninsured pop-  
10 ulations within each State in such year  
11 provided through population surveys con-  
12 ducted by federal agencies.

13 (ii) LIMITATION TO NONELDERLY.—

14 Such methodology shall exclude individuals  
15 who are 65 years of age or older.

16 (iii) EXCLUSION OF ILLEGAL

17 ALIENS.—Such methodology shall exclude

18 individuals not lawfully present in the

19 United States.

20 (6) CONDITIONS OF PAYMENT.—As a condition

21 of receiving a payment under paragraph (1), a State

22 must agree to submit aggregate, non-individually

23 identifiable data to the Secretary, in a form and

24 manner specified by the Secretary, for use by the

25 Secretary in determining the State's uninsured base-

1 line and uninsured performance level for purposes of  
2 this subsection.

3 (c) DEFINITIONS.—For purposes of this section:

4 (1) GROUP HEALTH PLAN.—The term “group  
5 health plan” has the meaning given such term in  
6 section 9832(a) of the Internal Revenue Code of  
7 1986.

8 (2) HEALTH INSURANCE COVERAGE.—The term  
9 “health insurance coverage” has the meaning given  
10 such term in section 9832(b)(1) of the Internal Rev-  
11 enue Code of 1986.

12 (3) INDIVIDUAL MARKET.—Except as the Sec-  
13 retary may otherwise provide in the case of group  
14 health plans that have fewer than 2 participants as  
15 current employees on the first day of a plan year,  
16 the term “individual market” means the market for  
17 health insurance coverage offered to individuals  
18 other than in connection with a group health plan.

19 (4) SECRETARY.—The term “Secretary” means  
20 the Secretary of Health and Human Services.

21 (5) SMALL GROUP MARKET.—The term “small  
22 group market” means the market for health insur-  
23 ance coverage under which individuals obtain health  
24 insurance coverage (directly or through any arrange-  
25 ment) on behalf of themselves (and their depend-

1 ents) through a group health plan maintained by an  
2 employer who employed on average at least 2 but  
3 not more than 50 employees on business days during  
4 a calendar year.

5 (6) STATE.—The term “State” means any of  
6 the 50 States and the District of Columbia.

7 (7) YEARS.—The terms “year 1”, “year 2”,  
8 “year 3”, and similar subsequently numbered years  
9 mean 2014, 2015, 2016, and subsequent sequen-  
10 tially numbered years.

11 (d) APPROPRIATIONS; PAYMENTS.—

12 (1) PAYMENTS FOR REDUCTIONS IN COST OF  
13 HEALTH INSURANCE COVERAGE.—

14 (A) SMALL GROUP MARKET.—

15 (i) IN GENERAL.—From any funds in  
16 the Treasury not otherwise appropriated,  
17 there is appropriated for payments under  
18 subsection (a)(1)(A)—

19 (I) \$18,000,000,000 with respect  
20 to performance in year 3;

21 (II) \$5,000,000,000 with respect  
22 to performance in year 6; and

23 (III) \$2,000,000,000 with re-  
24 spect to performance in year 9.

1 (ii) AVAILABILITY OF APPROPRIATED  
2 FUNDS.—Funds appropriated under clause  
3 (i) shall remain available until expended.

4 (B) INDIVIDUAL MARKET.—

5 (i) IN GENERAL.—Subject to clause  
6 (ii), from any funds in the Treasury not  
7 otherwise appropriated, there is appro-  
8 priated for payments under subsection  
9 (a)(1)(B)—

10 (I) \$7,000,000,000 with respect  
11 to performance in year 3;

12 (II) \$2,000,000,000 with respect  
13 to performance in year 6; and

14 (III) \$1,000,000,000 with re-  
15 spect to performance in year 9.

16 (ii) AVAILABILITY OF APPROPRIATED  
17 FUNDS.—Of the funds appropriated under  
18 clause (i) that are not expended or obli-  
19 gated by the end of the year following the  
20 year for which the funds are appro-  
21 priated—

22 (I) 75 percent shall remain avail-  
23 able until expended for payments  
24 under subsection (a)(1)(B); and

1 (II) 25 percent shall remain  
2 available until expended for payments  
3 under subsection (a)(1)(A).

4 (2) PAYMENTS FOR REDUCTIONS IN THE PER-  
5 CENTAGE OF UNINSURED.—

6 (A) IN GENERAL.—From any funds in the  
7 Treasury not otherwise appropriated, there is  
8 appropriated for payments under subsection  
9 (b)(1)—

10 (i) \$10,000,000,000 with respect to  
11 performance in year 5;

12 (ii) \$3,000,000,000 with respect to  
13 performance in year 7; and

14 (iii) \$2,000,000,000 with respect to  
15 performance in year 9.

16 (B) AVAILABILITY OF APPROPRIATED  
17 FUNDS.—Funds appropriated under subpara-  
18 graph (A) shall remain available until expended.

19 (3) PAYMENT TIMING.—Payments under this  
20 section shall be made in a form and manner speci-  
21 fied by the Secretary in the year after the perform-  
22 ance year involved.

23 **SEC. 612. HEALTH PLAN FINDERS.**

24 (a) STATE PLAN FINDERS.—Not later than 12  
25 months after the date of the enactment of this Act, each

1 State may contract with a private entity to develop and  
2 operate a plan finder website (referred to in this section  
3 as a “State plan finder”) which shall provide information  
4 to individuals in such State on plans of health insurance  
5 coverage that are available to individuals in such State (in  
6 this section referred to as a “health insurance plan”).  
7 Such State may not operate a plan finder itself.

8 (b) MULTI-STATE PLAN FINDERS.—

9 (1) IN GENERAL.—A private entity may operate  
10 a multi-State finder that operates under this section  
11 in the States involved in the same manner as a State  
12 plan finder would operate in a single State.

13 (2) SHARING OF INFORMATION.—States shall  
14 regulate the manner in which data is shared between  
15 plan finders to ensure consistency and accuracy in  
16 the information about health insurance plans con-  
17 tained in such finders.

18 (c) REQUIREMENTS FOR PLAN FINDERS.—Each plan  
19 finder shall meet the following requirements:

20 (1) The plan finder shall ensure that each  
21 health insurance plan in the plan finder meets the  
22 requirements for such plans under subsection (d).

23 (2) The plan finder shall present complete in-  
24 formation on the costs and benefits of health insur-  
25 ance plans (including information on monthly pre-



1 mium, copayments, and deductibles) in a uniform  
2 manner that—

3 (A) uses the standard definitions developed  
4 under paragraph (3); and

5 (B) is designed to allow consumers to eas-  
6 ily compare such plans.

7 (3) The plan finder shall be available on the  
8 Internet and accessible to all individuals in the State  
9 or, in the case of a multi-State plan finder, in all  
10 States covered by the multi-State plan finder.

11 (4) The plan finder shall allow consumers to  
12 search and sort data on the health insurance plans  
13 in the plan finder on criteria such as coverage of  
14 specific benefits (such as coverage of disease man-  
15 agement services or pediatric care services), as well  
16 as data available on quality.

17 (5) The plan finder shall meet all relevant State  
18 laws and regulations, including laws and regulations  
19 related to the marketing of insurance products. In  
20 the case of a multi-State plan finder, the finder shall  
21 meet such laws and regulations for all of the States  
22 involved.

23 (6) The plan finder shall meet solvency, finan-  
24 cial, and privacy requirements established by the

1 State or States in which the plan finder operates or  
2 the Secretary for multi-State finders.

3 (7) The plan finder and the employees of the  
4 plan finder shall be appropriately licensed in the  
5 State or States in which the plan finder operates, if  
6 such licensure is required by such State or States.

7 (8) Notwithstanding subsection (f)(1), the plan  
8 finder shall assist individuals who are eligible for the  
9 Medicaid program under title XIX of the Social Se-  
10 curity Act or State Children’s Health Insurance Pro-  
11 gram under title XXI of such Act by including infor-  
12 mation on Medicaid options, eligibility, and how to  
13 enroll.

14 (d) REQUIREMENTS FOR PLANS PARTICIPATING IN  
15 A PLAN FINDER.—

16 (1) IN GENERAL.—Each State shall ensure that  
17 health insurance plans participating in the State  
18 plan finder or in a multi-State plan finder meet the  
19 requirements of paragraph (2) (relating to adequacy  
20 of insurance coverage, consumer protection, and fi-  
21 nancial strength).

22 (2) SPECIFIC REQUIREMENTS.—In order to  
23 participate in a plan finder, a health insurance plan  
24 must meet all of the following requirements, as de-  
25 termined by each State in which such plan operates:

1 (A) The health insurance plan shall be ac-  
2 tuarially sound.

3 (B) The health insurance plan may not  
4 have a history of abusive policy rescissions.

5 (C) The health insurance plan shall meet  
6 financial and solvency requirements.

7 (D) The health insurance plan shall dis-  
8 close—

9 (i) all financial arrangements involv-  
10 ing the sale and purchase of health insur-  
11 ance, such as the payment of fees and  
12 commissions; and

13 (ii) such arrangements may not be  
14 abusive.

15 (E) The health insurance plan shall main-  
16 tain electronic health records that comply with  
17 the requirements of the American Recovery and  
18 Reinvestment Act of 2009 (Public Law 111–5)  
19 related to electronic health records.

20 (F) The health insurance plan shall make  
21 available to plan enrollees via the finder, wheth-  
22 er by information provided to the finder or by  
23 a website link directing the enrollee from the  
24 finder to the health insurance plan website,  
25 data that includes the price and cost to the in-

1 individual of services offered by a provider ac-  
2 cording to the terms and conditions of the  
3 health plan. Data described in this paragraph is  
4 not made public by the finder, only made avail-  
5 able to the individual once enrolled in the  
6 health plan.

7 (e) PROHIBITIONS.—

8 (1) DIRECT ENROLLMENT.—The State plan  
9 finder may not directly enroll individuals in health  
10 insurance plans.

11 (2) CONFLICTS OF INTEREST.—

12 (A) COMPANIES.—A health insurance  
13 issuer offering a health insurance plan through  
14 a plan finder may not—

15 (i) be the private entity developing  
16 and maintaining a plan finder under sub-  
17 sections (a) and (b); or

18 (ii) have an ownership interest in such  
19 private entity or in the plan finder.

20 (B) INDIVIDUALS.—An individual em-  
21 ployed by a health insurance issuer offering a  
22 health insurance plan through a plan finder  
23 may not serve as a director or officer for—

1 (i) the private entity developing and  
2 maintaining a plan finder under sub-  
3 sections (a) and (b); or

4 (ii) the plan finder.

5 (f) CONSTRUCTION.—Nothing in this section shall be  
6 construed to allow the Secretary authority to regulate ben-  
7 efit packages or to prohibit health insurance brokers and  
8 agents from—

9 (1) utilizing the plan finder for any purpose; or

10 (2) marketing or offering health insurance  
11 products.

12 (g) PLAN FINDER DEFINED.—For purposes of this  
13 section, the term “plan finder” means a State plan finder  
14 under subsection (a) or a multi-State plan finder under  
15 subsection (b).

16 (h) STATE DEFINED.—In this section, the term  
17 “State” has the meaning given such term for purposes of  
18 title XIX of the Social Security Act.

19 **SEC. 613. ADMINISTRATIVE SIMPLIFICATION.**

20 (a) OPERATING RULES FOR HEALTH INFORMATION  
21 TRANSACTIONS.—

22 (1) DEFINITION OF OPERATING RULES.—Sec-  
23 tion 1171 of the Social Security Act (42 U.S.C.  
24 1320d) is amended by adding at the end the fol-  
25 lowing:

1           “(9) OPERATING RULES.—The term ‘operating  
2 rules’ means the necessary business rules and guide-  
3 lines for the electronic exchange of information that  
4 are not defined by a standard or its implementation  
5 specifications as adopted for purposes of this part.”.

6           (2) OPERATING RULES AND COMPLIANCE.—  
7 Section 1173 of the Social Security Act (42 U.S.C.  
8 1320d–2) is amended—

9           (A) in subsection (a)(2), by adding at the  
10 end the following new subparagraph:

11           “(J) Electronic funds transfers.”; and

12           (B) by adding at the end the following new  
13 subsections:

14           “(g) OPERATING RULES.—

15           “(1) IN GENERAL.—The Secretary shall adopt  
16 a single set of operating rules for each transaction  
17 described in subsection (a)(2) with the goal of cre-  
18 ating as much uniformity in the implementation of  
19 the electronic standards as possible. Such operating  
20 rules shall be consensus-based and reflect the nec-  
21 essary business rules affecting health plans and  
22 health care providers and the manner in which they  
23 operate pursuant to standards issued under Health  
24 Insurance Portability and Accountability Act of  
25 1996.

1           “(2) OPERATING RULES DEVELOPMENT.—In  
2     adopting operating rules under this subsection, the  
3     Secretary shall rely on recommendations for oper-  
4     ating rules developed by a qualified nonprofit entity,  
5     as selected by the Secretary, that meets the fol-  
6     lowing requirements:

7           “(A) The entity focuses its mission on ad-  
8     ministrative simplification.

9           “(B) The entity demonstrates an estab-  
10    lished multi-stakeholder and consensus-based  
11    process for development of operating rules, in-  
12    cluding representation by or participation from  
13    health plans, health care providers, vendors, rel-  
14    evant Federal agencies, and other standard de-  
15    velopment organizations.

16          “(C) The entity has established a public  
17    set of guiding principles that ensure the oper-  
18    ating rules and process are open and trans-  
19    parent.

20          “(D) The entity coordinates its activities  
21    with the HIT Policy Committee and the HIT  
22    Standards Committee (as established under  
23    title XXX of the Public Health Service Act)  
24    and complements the efforts of the Office of the

1 National Healthcare Coordinator and its related  
2 health information exchange goals.

3 “(E) The entity incorporates national  
4 standards, including the transaction standards  
5 issued under Health Insurance Portability and  
6 Accountability Act of 1996.

7 “(F) The entity supports nondiscrimina-  
8 tion and conflict of interest policies that dem-  
9 onstrate a commitment to open, fair, and non-  
10 discriminatory practices.

11 “(G) The entity allows for public review  
12 and updates of the operating rules.

13 “(3) REVIEW AND RECOMMENDATIONS.—The  
14 National Committee on Vital and Health Statistics  
15 shall—

16 “(A) review the operating rules developed  
17 by a nonprofit entity described under paragraph  
18 (2);

19 “(B) determine whether such rules rep-  
20 resent a consensus view of the health care in-  
21 dustry and are consistent with and do not alter  
22 current standards;

23 “(C) evaluate whether such rules are con-  
24 sistent with electronic standards adopted for  
25 health information technology; and



1           “(D) submit to the Secretary a rec-  
2           ommendation as to whether the Secretary  
3           should adopt such rules.

4           “(4) IMPLEMENTATION.—

5           “(A) IN GENERAL.—The Secretary shall  
6           adopt operating rules under this subsection, by  
7           regulation in accordance with subparagraph  
8           (C), following consideration of the rules devel-  
9           oped by the non-profit entity described in para-  
10          graph (2) and the recommendation submitted  
11          by the National Committee on Vital and Health  
12          Statistics under paragraph (3)(D) and having  
13          ensured consultation with providers.

14          “(B) ADOPTION REQUIREMENTS; EFFEC-  
15          TIVE DATES.—

16          “(i) ELIGIBILITY FOR A HEALTH  
17          PLAN AND HEALTH CLAIM STATUS.—The  
18          set of operating rules for transactions for  
19          eligibility for a health plan and health  
20          claim status shall be adopted not later  
21          than July 1, 2015, in a manner ensuring  
22          that such rules are effective not later than  
23          January 1, 2017, and may allow for the  
24          use of a machine readable identification  
25          card.

1           “(ii) ELECTRONIC FUNDS TRANSFERS  
2           AND HEALTH CARE PAYMENT AND REMIT-  
3           TANCE ADVICE.—The set of operating  
4           rules for electronic funds transfers and  
5           health care payment and remittance advice  
6           shall be adopted not later than July 1,  
7           2016, in a manner ensuring that such  
8           rules are effective not later than January  
9           1, 2018.

10           “(iii) OTHER COMPLETED TRANS-  
11           ACTIONS.—The set of operating rules for  
12           the remainder of the completed trans-  
13           actions described in subsection (a)(2), in-  
14           cluding health claims or equivalent encoun-  
15           ter information, enrollment and  
16           disenrollment in a health plan, health plan  
17           premium payments, and referral certifi-  
18           cation and authorization, shall be adopted  
19           not later than July 1, 2018, in a manner  
20           ensuring that such rules are effective not  
21           later than January 1, 2020.

22           “(C) EXPEDITED RULEMAKING.—The Sec-  
23           retary shall promulgate an interim final rule  
24           applying any standard or operating rule rec-  
25           ommended by the National Committee on Vital

1 and Health Statistics pursuant to paragraph  
2 (3). The Secretary shall accept public comments  
3 on any interim final rule published under this  
4 subparagraph for 60 days after the date of such  
5 publication.

6 “(h) COMPLIANCE.—

7 “(1) HEALTH PLAN CERTIFICATION.—

8 “(A) ELIGIBILITY FOR A HEALTH PLAN,  
9 HEALTH CLAIM STATUS, ELECTRONIC FUNDS  
10 TRANSFERS, HEALTH CARE PAYMENT AND RE-  
11 MITTANCE ADVICE.—Not later than December  
12 31, 2017, a health plan shall file a statement  
13 with the Secretary, in such form as the Sec-  
14 retary may require, certifying that the data and  
15 information systems for such plan are in com-  
16 pliance with any applicable standards (as de-  
17 scribed under paragraph (7) of section 1171)  
18 and operating rules (as described under para-  
19 graph (9) of such section) for electronic funds  
20 transfers, eligibility for a health plan, health  
21 claim status, and health care payment and re-  
22 mittance advice, respectively.

23 “(B) OTHER COMPLETED TRANS-  
24 ACTIONS.—Not later than December 31, 2019,  
25 a health plan shall file a statement with the

1 Secretary, in such form as the Secretary may  
2 require, certifying that the data and informa-  
3 tion systems for such plan are in compliance  
4 with any applicable standards and operating  
5 rules for the remainder of the completed trans-  
6 actions described in subsection (a)(2), including  
7 health claims or equivalent encounter informa-  
8 tion, enrollment and disenrollment in a health  
9 plan, health plan premium payments, and refer-  
10 ral certification and authorization, respectively.  
11 A health plan shall provide the same level of  
12 documentation to certify compliance with such  
13 transactions as is required to certify compliance  
14 with the transactions specified in subparagraph  
15 (A).

16 “(2) DOCUMENTATION OF COMPLIANCE.—A  
17 health plan shall provide the Secretary, in such form  
18 as the Secretary may require, with adequate docu-  
19 mentation of compliance with the standards and op-  
20 erating rules described under paragraph (1). A  
21 health plan shall not be considered to have provided  
22 adequate documentation and shall not be certified as  
23 being in compliance with such standards, unless the  
24 health plan—

1           “(A) demonstrates to the Secretary that  
2           the plan conducts the electronic transactions  
3           specified in paragraph (1) in a manner that  
4           fully complies with the regulations of the Sec-  
5           retary; and

6           “(B) provides documentation showing that  
7           the plan has completed end-to-end testing for  
8           such transactions with their partners, such as  
9           hospitals and physicians.

10          “(3) SERVICE CONTRACTS.—A health plan shall  
11          be required to comply with any applicable certifi-  
12          cation and compliance requirements (and provide the  
13          Secretary with adequate documentation of such com-  
14          pliance) under this subsection for any entities that  
15          provide services pursuant to a contract with such  
16          health plan.

17          “(4) CERTIFICATION BY OUTSIDE ENTITY.—  
18          The Secretary may contract with an independent,  
19          outside entity to certify that a health plan has com-  
20          plied with the requirements under this subsection,  
21          provided that the certification standards employed  
22          by such entities are in accordance with any stand-  
23          ards or rules issued by the Secretary.

24          “(5) COMPLIANCE WITH REVISED STANDARDS  
25          AND RULES.—A health plan (including entities de-

1 scribed under paragraph (3)) shall comply with the  
2 certification and documentation requirements under  
3 this subsection for any interim final rule promul-  
4 gated by the Secretary under subsection (i) that  
5 amends any standard or operating rule described  
6 under paragraph (1) of this subsection. A health  
7 plan shall comply with such requirements not later  
8 than the effective date of the applicable interim final  
9 rule.

10 “(6) AUDITS OF HEALTH PLANS.—The Sec-  
11 retary shall conduct periodic audits to ensure that  
12 health plans (including entities described under  
13 paragraph (3)) are in compliance with any standards  
14 and operating rules that are described under para-  
15 graph (1).

16 “(i) REVIEW AND AMENDMENT OF STANDARDS AND  
17 RULES.—

18 “(1) ESTABLISHMENT.—Not later than Janu-  
19 ary 1, 2018, the Secretary shall establish a review  
20 committee (as described under paragraph (4)).

21 “(2) EVALUATIONS AND REPORTS.—

22 “(A) HEARINGS.—Not later than April 1,  
23 2018, and not less than biennially thereafter,  
24 the Secretary, acting through the review com-  
25 mittee, shall conduct hearings to evaluate and

1 review the existing standards and operating  
2 rules established under this section.

3 “(B) REPORT.—Not later than July 1,  
4 2018, and not less than biennially thereafter,  
5 the review committee shall provide rec-  
6 ommendations for updating and improving such  
7 standards and rules. The review committee  
8 shall recommend a single set of operating rules  
9 per transaction standard and maintain the goal  
10 of creating as much uniformity as possible in  
11 the implementation of the electronic standards.

12 “(3) INTERIM FINAL RULEMAKING.—

13 “(A) IN GENERAL.—Any recommendations  
14 to amend existing standards and operating  
15 rules that have been approved by the review  
16 committee and reported to the Secretary under  
17 paragraph (2)(B) shall be adopted by the Sec-  
18 retary through promulgation of an interim final  
19 rule not later than 90 days after receipt of the  
20 committee’s report.

21 “(B) PUBLIC COMMENT.—

22 “(i) PUBLIC COMMENT PERIOD.—The  
23 Secretary shall accept public comments on  
24 any interim final rule published under this

1 paragraph for 60 days after the date of  
2 such publication.

3 “(ii) EFFECTIVE DATE.—The effective  
4 date of any amendment to existing stand-  
5 ards or operating rules that is adopted  
6 through an interim final rule published  
7 under this paragraph shall be 25 months  
8 following the close of such public comment  
9 period.

10 “(4) REVIEW COMMITTEE.—

11 “(A) DEFINITION.—For the purposes of  
12 this subsection, the term ‘review committee’  
13 means a committee within the Department of  
14 Health and Human services that has been des-  
15 ignated by the Secretary to carry out this sub-  
16 section, including—

17 “(i) the National Committee on Vital  
18 and Health Statistics; or

19 “(ii) any appropriate committee as de-  
20 termined by the Secretary.

21 “(B) COORDINATION OF HIT STAND-  
22 ARDS.—In developing recommendations under  
23 this subsection, the review committee shall con-  
24 sider the standards approved by the Office of



1 the National Coordinator for Health Informa-  
2 tion Technology.

3 “(j) PENALTIES.—

4 “(1) PENALTY FEE.—

5 “(A) IN GENERAL.—Not later than April  
6 1, 2018, and annually thereafter, the Secretary  
7 shall assess a penalty fee (as determined under  
8 subparagraph (B)) against a health plan that  
9 has failed to meet the requirements under sub-  
10 section (h) with respect to certification and doc-  
11 umentation of compliance with the standards  
12 (and their operating rules) as described under  
13 paragraph (1) of such subsection.

14 “(B) FEE AMOUNT.—Subject to subpara-  
15 graphs (C), (D), and (E), the Secretary shall  
16 assess a penalty fee against a health plan in the  
17 amount of \$1 per covered life until certification  
18 is complete. The penalty shall be assessed per  
19 person covered by the plan for which its data  
20 systems for major medical policies are not in  
21 compliance and shall be imposed against the  
22 health plan for each day that the plan is not in  
23 compliance with the requirements under sub-  
24 section (h).

1           “(C) ADDITIONAL PENALTY FOR MIS-  
2 REPRESENTATION.—A health plan that know-  
3 ingly provides inaccurate or incomplete informa-  
4 tion in a statement of certification or docu-  
5 mentation of compliance under subsection (h)  
6 shall be subject to a penalty fee that is double  
7 the amount that would otherwise be imposed  
8 under this subsection.

9           “(D) ANNUAL FEE INCREASE.—The  
10 amount of the penalty fee imposed under this  
11 subsection shall be increased on an annual basis  
12 by the annual percentage increase in total na-  
13 tional health care expenditures, as determined  
14 by the Secretary.

15           “(E) PENALTY LIMIT.—A penalty fee as-  
16 sessed against a health plan under this sub-  
17 section shall not exceed, on an annual basis—

18                   “(i) an amount equal to \$20 per cov-  
19 ered life under such plan; or

20                   “(ii) an amount equal to \$40 per cov-  
21 ered life under the plan if such plan has  
22 knowingly provided inaccurate or incom-  
23 plete information (as described under sub-  
24 paragraph (C)).

1           “(F) DETERMINATION OF COVERED INDI-  
2           VIDUALS.—The Secretary shall determine the  
3           number of covered lives under a health plan  
4           based upon the most recent statements and fil-  
5           ings that have been submitted by such plan to  
6           the Securities and Exchange Commission.

7           “(2) NOTICE AND DISPUTE PROCEDURE.—The  
8           Secretary shall establish a procedure for assessment  
9           of penalty fees under this subsection that provides a  
10          health plan with reasonable notice and a dispute res-  
11          olution procedure prior to provision of a notice of as-  
12          sessment by the Secretary of the Treasury (as de-  
13          scribed under paragraph (4)(B)).

14          “(3) PENALTY FEE REPORT.—Not later than  
15          May 1, 2018, and annually thereafter, the Secretary  
16          shall provide the Secretary of the Treasury with a  
17          report identifying those health plans that have been  
18          assessed a penalty fee under this subsection.

19          “(4) COLLECTION OF PENALTY FEE.—

20                 “(A) IN GENERAL.—The Secretary of the  
21                 Treasury, acting through the Financial Man-  
22                 agement Service, shall administer the collection  
23                 of penalty fees from health plans that have been  
24                 identified by the Secretary in the penalty fee re-  
25                 port provided under paragraph (3).

1           “(B) NOTICE.—Not later than August 1,  
2           2018, and annually thereafter, the Secretary of  
3           the Treasury shall provide notice to each health  
4           plan that has been assessed a penalty fee by the  
5           Secretary under this subsection. Such notice  
6           shall include the amount of the penalty fee as-  
7           sessed by the Secretary and the due date for  
8           payment of such fee to the Secretary of the  
9           Treasury (as described in subparagraph (C)).

10           “(C) PAYMENT DUE DATE.—Payment by a  
11           health plan for a penalty fee assessed under  
12           this subsection shall be made to the Secretary  
13           of the Treasury not later than November 1,  
14           2018, and annually thereafter.

15           “(D) UNPAID PENALTY FEES.—Any  
16           amount of a penalty fee assessed against a  
17           health plan under this subsection for which pay-  
18           ment has not been made by the due date pro-  
19           vided under subparagraph (C) shall be—

20                   “(i) increased by the interest accrued  
21                   on such amount, as determined pursuant  
22                   to the underpayment rate established  
23                   under section 6601 of the Internal Rev-  
24                   enue Code of 1986; and

1           “(ii) treated as a past-due, legally en-  
2           forceable debt owed to a Federal agency  
3           for purposes of section 6402(d) of the In-  
4           ternal Revenue Code of 1986.

5           “(E) ADMINISTRATIVE FEES.—Any fee  
6           charged or allocated for collection activities con-  
7           ducted by the Financial Management Service  
8           will be passed on to a health plan on a pro-rata  
9           basis and added to any penalty fee collected  
10          from the plan.”.

11          (b) PROMULGATION OF RULES.—

12           (1) UNIQUE HEALTH PLAN IDENTIFIER.—The  
13          Secretary shall promulgate a final rule to establish  
14          a unique health plan identifier (as described in sec-  
15          tion 1173(b) of the Social Security Act (42 U.S.C.  
16          1320d–2(b))) based on the input of the National  
17          Committee of Vital and Health Statistics. The Sec-  
18          retary may do so on an interim final basis and such  
19          rule shall be effective not later than October 1,  
20          2016.

21           (2) ELECTRONIC FUNDS TRANSFER.—The Sec-  
22          retary shall promulgate a final rule to establish a  
23          standard for electronic funds transfers (as described  
24          in section 1173(a)(2)(J) of the Social Security Act,  
25          as added by subsection (a)(2)(A)). The Secretary

1 may do so on an interim final basis and shall adopt  
2 such standard not later than January 1, 2016, in a  
3 manner ensuring that such standard is effective not  
4 later than January 1, 2018.

5 (c) EXPANSION OF ELECTRONIC TRANSACTIONS IN  
6 MEDICARE.—Section 1862(a) of the Social Security Act  
7 (42 U.S.C. 1395y(a)) is amended—

8 (1) in paragraph (23), by striking the “or” at  
9 the end;

10 (2) in paragraph (24), by striking the period  
11 and inserting “; or”; and

12 (3) by inserting after paragraph (24) the fol-  
13 lowing new paragraph:

14 “(25) not later than January 1, 2018, for  
15 which the payment is other than by electronic funds  
16 transfer (EFT) or an electronic remittance in a form  
17 as specified in ASC X12 835 Health Care Payment  
18 and Remittance Advice or subsequent standard.”.

19 (d) MEDICARE AND MEDICAID COMPLIANCE RE-  
20 PORTS.—Not later than July 1, 2017, the Secretary of  
21 Health and Human Services shall submit a report to the  
22 chairs and ranking members of the Committee on Ways  
23 and Means and the Committee on Energy and Commerce  
24 of the House of Representatives and the chairs and rank-  
25 ing members of the Committee on Health, Education,

1 Labor, and Pensions and the Committee on Finance of  
2 the Senate on the extent to which the Medicare program  
3 and providers that serve beneficiaries under that program,  
4 and State Medicaid programs and providers that serve  
5 beneficiaries under those programs, transact electronically  
6 in accordance with transaction standards issued under the  
7 Health Insurance Portability and Accountability Act of  
8 1996, part C of title XI of the Social Security Act, and  
9 regulations promulgated under such Acts.

10 **Subtitle B—Improving Access to**  
11 **Health Care**

12 **CHAPTER 1—EXPANDING ACCESS AND**  
13 **LOWERING COSTS FOR SMALL BUSI-**  
14 **NESSES**

15 **SEC. 620. SHORT TITLE.**

16 This chapter may be cited as the “Small Business  
17 Health Fairness Act of 2013”.

18 **SEC. 621. RULES GOVERNING ASSOCIATION HEALTH**  
19 **PLANS.**

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

**1       “PART 8—RULES GOVERNING ASSOCIATION****2                               HEALTH PLANS****3       “SEC. 801. ASSOCIATION HEALTH PLANS.**

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

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

10               “(1) is organized and maintained in good faith,  
11 with a constitution and bylaws specifically stating its  
12 purpose and providing for periodic meetings on at  
13 least an annual basis, as a bona fide trade associa-  
14 tion, a bona fide industry association (including a  
15 rural electric cooperative association or a rural tele-  
16 phone cooperative association), a bona fide profes-  
17 sional association, or a bona fide chamber of com-  
18 merce (or similar bona fide business association, in-  
19 cluding a corporation or similar organization that  
20 operates on a cooperative basis (within the meaning  
21 of section 1381 of the Internal Revenue Code of  
22 1986)), for substantial purposes other than that of  
23 obtaining or providing medical care;

24               “(2) is established as a permanent entity which  
25 receives the active support of its members and re-  
26 quires for membership payment on a periodic basis



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

3 “(3) does not condition membership, such dues  
4 or payments, or coverage under the plan on the  
5 basis of health status-related factors with respect to  
6 the employees of its members (or affiliated mem-  
7 bers), or the dependents of such employees, and does  
8 not condition such dues or payments on the basis of  
9 group health plan participation.

10 Any sponsor consisting of an association of entities which  
11 meet the requirements of paragraphs (1), (2), and (3)  
12 shall be deemed to be a sponsor described in this sub-  
13 section.

14 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
15 **PLANS.**

16 “(a) IN GENERAL.—The applicable authority shall  
17 prescribe by regulation a procedure under which, subject  
18 to subsection (b), the applicable authority shall certify as-  
19 sociation health plans which apply for certification as  
20 meeting the requirements of this part.

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

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

5       “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
6 PLANS.—An association health plan with respect to which  
7 certification under this part is in effect shall meet the ap-  
8 plicable requirements of this part, effective on the date  
9 of certification (or, if later, on the date on which the plan  
10 is to commence operations).

11       “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
12 CATION.—The applicable authority may provide by regula-  
13 tion for continued certification of association health plans  
14 under this part.

15       “(e) CLASS CERTIFICATION FOR FULLY INSURED  
16 PLANS.—The applicable authority shall establish a class  
17 certification procedure for association health plans under  
18 which all benefits consist of health insurance coverage.  
19 Under such procedure, the applicable authority shall pro-  
20 vide for the granting of certification under this part to  
21 the plans in each class of such association health plans  
22 upon appropriate filing under such procedure in connec-  
23 tion with plans in such class and payment of the pre-  
24 scribed fee under section 807(a).

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

6           “(1) a plan which offered such coverage on the  
7 date of the enactment of the Small Business Health  
8 Fairness Act of 2013,

9           “(2) a plan under which the sponsor does not  
10 restrict membership to one or more trades and busi-  
11 nesses or industries and whose eligible participating  
12 employers represent a broad cross-section of trades  
13 and businesses or industries, or

14           “(3) a plan whose eligible participating employ-  
15 ers represent one or more trades or businesses, or  
16 one or more industries, consisting of any of the fol-  
17 lowing: agriculture; equipment and automobile deal-  
18 erships; barbering and cosmetology; certified public  
19 accounting practices; child care; construction; dance,  
20 theatrical and orchestra productions; disinfecting  
21 and pest control; financial services; fishing; food  
22 service establishments; hospitals; labor organiza-  
23 tions; logging; manufacturing (metals); mining; med-  
24 ical and dental practices; medical laboratories; pro-  
25 fessional consulting services; sanitary services; trans-

1 portation (local and freight); warehousing; whole-  
2 saling/distributing; or any other trade or business or  
3 industry which has been indicated as having average  
4 or above-average risk or health claims experience by  
5 reason of State rate filings, denials of coverage, pro-  
6 posed premium rate levels, or other means dem-  
7 onstrated by such plan in accordance with regula-  
8 tions.

9 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
10 **BOARDS OF TRUSTEES.**

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

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

20 “(1) FISCAL CONTROL.—The plan is operated,  
21 pursuant to a trust agreement, by a board of trust-  
22 ees which has complete fiscal control over the plan  
23 and which is responsible for all operations of the  
24 plan.

1           “(2) RULES OF OPERATION AND FINANCIAL  
2           CONTROLS.—The board of trustees has in effect  
3           rules of operation and financial controls, based on a  
4           3-year plan of operation, adequate to carry out the  
5           terms of the plan and to meet all requirements of  
6           this title applicable to the plan.

7           “(3) RULES GOVERNING RELATIONSHIP TO  
8           PARTICIPATING EMPLOYERS AND TO CONTRAC-  
9           TORS.—

10           “(A) BOARD MEMBERSHIP.—

11           “(i) IN GENERAL.—Except as pro-  
12           vided in clauses (ii) and (iii), the members  
13           of the board of trustees are individuals se-  
14           lected from individuals who are the owners,  
15           officers, directors, or employees of the par-  
16           ticipating employers or who are partners in  
17           the participating employers and actively  
18           participate in the business.

19           “(ii) LIMITATION.—

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

1           “(II) LIMITED EXCEPTION FOR  
2 PROVIDERS OF SERVICES SOLELY ON  
3 BEHALF OF THE SPONSOR.—Officers  
4 or employees of a sponsor which is a  
5 service provider (other than a contract  
6 administrator) to the plan may be  
7 members of the board if they con-  
8 stitute not more than 25 percent of  
9 the membership of the board and they  
10 do not provide services to the plan  
11 other than on behalf of the sponsor.

12           “(III) TREATMENT OF PRO-  
13 VIDERS OF MEDICAL CARE.—In the  
14 case of a sponsor which is an associa-  
15 tion whose membership consists pri-  
16 marily of providers of medical care,  
17 subclause (I) shall not apply in the  
18 case of any service provider described  
19 in subclause (I) who is a provider of  
20 medical care under the plan.

21           “(iii) CERTAIN PLANS EXCLUDED.—  
22 Clause (i) shall not apply to an association  
23 health plan which is in existence on the  
24 date of the enactment of the Small Busi-  
25 ness Health Fairness Act of 2013.

1           “(B) SOLE AUTHORITY.—The board has  
2           sole authority under the plan to approve appli-  
3           cations for participation in the plan and to con-  
4           tract with a service provider to administer the  
5           day-to-day affairs of the plan.

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

10           “(1) the requirements of subsection (a) and sec-  
11           tion 801(a) shall be deemed met if such require-  
12           ments would otherwise be met if the franchiser were  
13           deemed to be the sponsor referred to in section  
14           801(b), such network were deemed to be an associa-  
15           tion described in section 801(b), and each franchisee  
16           were deemed to be a member (of the association and  
17           the sponsor) referred to in section 801(b); and

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

20           The Secretary may by regulation define for purposes of  
21           this subsection the terms ‘franchiser’, ‘franchise network’,  
22           and ‘franchisee’.

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

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

7 “(1) each participating employer must be—

8 “(A) a member of the sponsor,

9 “(B) the sponsor, or

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

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

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

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



1 employees of, or partners in, participating em-  
2 ployers; or

3 “(B) the beneficiaries of individuals de-  
4 scribed in subparagraph (A).

5 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
6 PLOYEES.—In the case of an association health plan in  
7 existence on the date of the enactment of the Small Busi-  
8 ness Health Fairness Act of 2013, an affiliated member  
9 of the sponsor of the plan may be offered coverage under  
10 the plan as a participating employer only if—

11 “(1) the affiliated member was an affiliated  
12 member on the date of certification under this part;  
13 or

14 “(2) during the 12-month period preceding the  
15 date of the offering of such coverage, the affiliated  
16 member has not maintained or contributed to a  
17 group health plan with respect to any of its employ-  
18 ees who would otherwise be eligible to participate in  
19 such association health plan.

20 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
21 quirements of this subsection are met with respect to an  
22 association health plan if, under the terms of the plan,  
23 no participating employer may provide health insurance  
24 coverage in the individual market for any employee not  
25 covered under the plan which is similar to the coverage

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

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

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

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

22           “(3) the applicable requirements of sections  
23 701, 702, and 703 are met with respect to the plan.

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

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

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

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

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

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

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

24 “(A) The contribution rates for any par-  
25 ticipating small employer do not vary on the  
26 basis of any health status-related factor in rela-

1           tion to employees of such employer or their  
2           beneficiaries and do not vary on the basis of the  
3           type of business or industry in which such em-  
4           ployer is engaged.

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

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

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

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

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

7           “(4) MARKETING REQUIREMENTS.—

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

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

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

6           “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
7 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
8 nothing in this part or any provision of State law (as de-  
9 fined in section 514(c)(1)) shall be construed to preclude  
10 an association health plan, or a health insurance issuer  
11 offering health insurance coverage in connection with an  
12 association health plan, from exercising its sole discretion  
13 in selecting the specific items and services consisting of  
14 medical care to be included as benefits under such plan  
15 or coverage, except (subject to section 514) in the case  
16 of (1) any law to the extent that it is not preempted under  
17 section 731(a)(1) with respect to matters governed by sec-  
18 tion 711, 712, or 713, or (2) any law of the State with  
19 which filing and approval of a policy type offered by the  
20 plan was initially obtained to the extent that such law pro-  
21 hibits an exclusion of a specific disease from such cov-  
22 erage.

1 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
2 **FOR SOLVENCY FOR PLANS PROVIDING**  
3 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
4 **INSURANCE COVERAGE.**

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

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

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

12 “(A) establishes and maintains reserves  
13 with respect to such additional benefit options,  
14 in amounts recommended by the qualified actu-  
15 ary, consisting of—

16 “(i) a reserve sufficient for unearned  
17 contributions;

18 “(ii) a reserve sufficient for benefit li-  
19 abilities which have been incurred, which  
20 have not been satisfied, and for which risk  
21 of loss has not yet been transferred, and  
22 for expected administrative costs with re-  
23 spect to such benefit liabilities;

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

1           “(iv) a reserve sufficient for a margin  
2           of error and other fluctuations, taking into  
3           account the specific circumstances of the  
4           plan; and

5           “(B) establishes and maintains aggregate  
6           and specific excess/stop loss insurance and sol-  
7           vency indemnification, with respect to such ad-  
8           ditional benefit options for which risk of loss  
9           has not yet been transferred, as follows:

10           “(i) The plan shall secure aggregate  
11           excess/stop loss insurance for the plan with  
12           an attachment point which is not greater  
13           than 125 percent of expected gross annual  
14           claims. The applicable authority may by  
15           regulation provide for upward adjustments  
16           in the amount of such percentage in speci-  
17           fied circumstances in which the plan spe-  
18           cifically provides for and maintains re-  
19           serves in excess of the amounts required  
20           under subparagraph (A).

21           “(ii) The plan shall secure specific ex-  
22           cess/stop loss insurance for the plan with  
23           an attachment point which is at least equal  
24           to an amount recommended by the plan’s  
25           qualified actuary. The applicable authority



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

7           “(iii) The plan shall secure indem-  
8           nification insurance for any claims which  
9           the plan is unable to satisfy by reason of  
10          a plan termination.

11 Any person issuing to a plan insurance described in clause  
12 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
13 retary of any failure of premium payment meriting can-  
14 cellation of the policy prior to undertaking such a cancella-  
15 tion. Any regulations prescribed by the applicable author-  
16 ity pursuant to clause (i) or (ii) of subparagraph (B) may  
17 allow for such adjustments in the required levels of excess/  
18 stop loss insurance as the qualified actuary may rec-  
19 ommend, taking into account the specific circumstances  
20 of the plan.

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

1           “(1) \$500,000, or

2           “(2) such greater amount (but not greater than  
3        \$2,000,000) as may be set forth in regulations pre-  
4        scribed by the applicable authority, considering the  
5        level of aggregate and specific excess/stop loss insur-  
6        ance provided with respect to such plan and other  
7        factors related to solvency risk, such as the plan’s  
8        projected levels of participation or claims, the nature  
9        of the plan’s liabilities, and the types of assets avail-  
10       able to assure that such liabilities are met.

11       “(c) **ADDITIONAL REQUIREMENTS.**—In the case of  
12 any association health plan described in subsection (a)(2),  
13 the applicable authority may provide such additional re-  
14 quirements relating to reserves, excess/stop loss insurance,  
15 and indemnification insurance as the applicable authority  
16 considers appropriate. Such requirements may be provided  
17 by regulation with respect to any such plan or any class  
18 of such plans.

19       “(d) **ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-**  
20 **ANCE.**—The applicable authority may provide for adjust-  
21 ments to the levels of reserves otherwise required under  
22 subsections (a) and (b) with respect to any plan or class  
23 of plans to take into account excess/stop loss insurance  
24 provided with respect to such plan or plans.

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

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

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

24                           “(A) IN GENERAL.—In the case of an as-  
25 sociation health plan described in subsection

1 (a)(2), the requirements of this subsection are  
2 met if the plan makes payments into the Asso-  
3 ciation Health Plan Fund under this subpara-  
4 graph when they are due. Such payments shall  
5 consist of annual payments in the amount of  
6 \$5,000, and, in addition to such annual pay-  
7 ments, such supplemental payments as the Sec-  
8 retary may determine to be necessary under  
9 paragraph (2). Payments under this paragraph  
10 are payable to the Fund at the time determined  
11 by the Secretary. Initial payments are due in  
12 advance of certification under this part. Pay-  
13 ments shall continue to accrue until a plan's as-  
14 sets are distributed pursuant to a termination  
15 procedure.

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

22 “(C) CONTINUED DUTY OF THE SEC-  
23 RETARY.—The Secretary shall not cease to  
24 carry out the provisions of paragraph (2) on ac-

1 count of the failure of a plan to pay any pay-  
2 ment when due.

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

1           “(3) ASSOCIATION HEALTH PLAN FUND.—

2                   “(A) IN GENERAL.—There is established  
3           on the books of the Treasury a fund to be  
4           known as the ‘Association Health Plan Fund’.  
5           The Fund shall be available for making pay-  
6           ments pursuant to paragraph (2). The Fund  
7           shall be credited with payments received pursu-  
8           ant to paragraph (1)(A), penalties received pur-  
9           suant to paragraph (1)(B); and earnings on in-  
10          vestments of amounts of the Fund under sub-  
11          paragraph (B).

12                   “(B) INVESTMENT.—Whenever the Sec-  
13          retary determines that the moneys of the fund  
14          are in excess of current needs, the Secretary  
15          may request the investment of such amounts as  
16          the Secretary determines advisable by the Sec-  
17          retary of the Treasury in obligations issued or  
18          guaranteed by the United States.

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

21                   “(1) AGGREGATE EXCESS/STOP LOSS INSUR-  
22          ANCE.—The term ‘aggregate 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 aggregate  
5           claims under the plan in excess of an amount  
6           or amounts specified in such contract;

7           “(B) which is guaranteed renewable; and

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

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

15               “(A) under which an insurer (meeting such  
16               minimum standards as the applicable authority  
17               may prescribe by regulation) provides for pay-  
18               ment to the plan with respect to claims under  
19               the plan in connection with a covered individual  
20               in excess of an amount or amounts specified in  
21               such contract in connection with such covered  
22               individual;

23               “(B) which is guaranteed renewable; and

1           “(C) which allows for payment of pre-  
2           miums by any third party on behalf of the in-  
3           sured plan.

4           “(h) INDEMNIFICATION INSURANCE.—For purposes  
5 of this section, the term ‘indemnification insurance’  
6 means, in connection with an association health plan, a  
7 contract—

8           “(1) under which an insurer (meeting such min-  
9           imum standards as the applicable authority may pre-  
10          scribe by regulation) provides for payment to the  
11          plan with respect to claims under the plan which the  
12          plan is unable to satisfy by reason of a termination  
13          pursuant to section 809(b) (relating to mandatory  
14          termination);

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

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

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



1 “(j) SOLVENCY STANDARDS WORKING GROUP.—

2 “(1) IN GENERAL.—Within 90 days after the  
3 date of the enactment of the Small Business Health  
4 Fairness Act of 2013, the applicable authority shall  
5 establish a Solvency Standards Working Group. In  
6 prescribing the initial regulations under this section,  
7 the applicable authority shall take into account the  
8 recommendations of such Working Group.

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

15 “(A) a representative of the National Asso-  
16 ciation of Insurance Commissioners;

17 “(B) a representative of the American  
18 Academy of Actuaries;

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

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

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

1           “(F) a representative of multiemployer  
2           plans that are group health plans, or their in-  
3           terests.

4   **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
5           **LATED REQUIREMENTS.**

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

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

21                  “(1) **IDENTIFYING INFORMATION.**—The names  
22                  and addresses of—

23                                  “(A) the sponsor; and

24                                  “(B) the members of the board of trustees  
25                  of the plan.

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

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

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

17           “(5) AGREEMENTS WITH SERVICE PRO-  
18 VIDERS.—A copy of any agreements between the  
19 plan and contract administrators and other service  
20 providers.

21           “(6) FUNDING REPORT.—In the case of asso-  
22 ciation health plans providing benefits options in ad-  
23 dition to health insurance coverage, a report setting  
24 forth information with respect to such additional  
25 benefit options determined as of a date within the

1 120-day period ending with the date of the applica-  
2 tion, including the following:

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

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

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

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

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

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

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

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

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

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

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

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

16               “(1) are in the aggregate reasonably related to  
17 the experience of the plan and to reasonable expecta-  
18 tions; and

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

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

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
2 **MINATION.**

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

9 “(1) provides to the participants and bene-  
10 ficiaries a written notice of intent to terminate stat-  
11 ing that such termination is intended and the pro-  
12 posed termination date;

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

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

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

22 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
23 **NATION.**

24 “(a) ACTIONS TO AVOID DEPLETION OF RE-  
25 SERVES.—An association health plan which is certified  
26 under this part and which provides benefits other than



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

1       “(b) MANDATORY TERMINATION.—In any case in  
2 which—

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

13           “(2) the applicable authority determines that  
14 there is a reasonable expectation that the plan will  
15 continue to fail to meet the requirements of section  
16 806,

17 the board of trustees of the plan shall, at the direction  
18 of the applicable authority, terminate the plan and, in the  
19 course of the termination, take such actions as the appli-  
20 cable authority may require, including satisfying any  
21 claims referred to in section 806(a)(2)(B)(iii) and recov-  
22 ering for the plan any liability under subsection  
23 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
24 that the affairs of the plan will be, to the maximum extent

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

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

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

1 tence of this subsection are remedied or the plan is termi-  
2 nated.

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

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

9 “(2) to require the transfer of all (or any part)  
10 of the assets and records of the plan to the Sec-  
11 retary as trustee;

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

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

22 “(5) to collect for the plan any amounts due the  
23 plan and to recover reasonable expenses of the trust-  
24 eeship;

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

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

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

13           “(9) to provide for the enrollment of plan par-  
14 ticipants and beneficiaries under appropriate cov-  
15 erage options; and

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

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

24           “(1) the sponsor and plan administrator;

25           “(2) each participant;

1           “(3) each participating employer; and

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

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

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

19          “(f) JURISDICTION OF COURT.—

20               “(1) IN GENERAL.—Upon the filing of an appli-  
21      cation for the appointment as trustee or the issuance  
22      of a decree under this section, the court to which the  
23      application is made shall have exclusive jurisdiction  
24      of the plan involved and its property wherever lo-  
25      cated with the powers, to the extent consistent with

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

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

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

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

8       “(a) IN GENERAL.—Notwithstanding section 514, a  
9 State may impose by law a contribution tax on an associa-  
10 tion health plan described in section 806(a)(2), if the plan  
11 commenced operations in such State after the date of the  
12 enactment of the Small Business Health Fairness Act of  
13 2013.

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

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

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



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

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

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

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

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

21 “(1) GROUP HEALTH PLAN.—The term ‘group  
22 health plan’ has the meaning provided in section  
23 733(a)(1) (after applying subsection (b) of this sec-  
24 tion).

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

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

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

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

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

19           “(7) INDIVIDUAL MARKET.—

20           “(A) IN GENERAL.—The term ‘individual  
21 market’ means the market for health insurance  
22 coverage offered to individuals other than in  
23 connection with a group health plan.

24           “(B) TREATMENT OF VERY SMALL  
25 GROUPS.—

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

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

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

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

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

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

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

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

18 “(B) in the case of a sponsor with mem-  
19 bers which consist of associations, a person who  
20 is a member of any such association and elects  
21 an affiliated status with the sponsor, or

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

1           2013, a person eligible to be a member of the  
2           sponsor or one of its member associations.

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

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

14           “(b) RULES OF CONSTRUCTION.—

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

22                   “(A) in the case of a partnership, the term  
23           ‘employer’ (as defined in section 3(5)) includes  
24           the partnership in relation to the partners, and  
25           the term ‘employee’ (as defined in section 3(6))

1 includes any partner in relation to the partner-  
2 ship; and

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

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

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

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

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

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

7           (A) in subsection (b)(4), by striking “Sub-  
8 section (a)” and inserting “Subsections (a) and  
9 (d)”;

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

17          (C) by redesignating subsections (d) and  
18 (e) as subsections (e) and (f), respectively; and

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

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

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

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

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

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



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

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

9               “(A) providing solvency standards or similar  
10       standards regarding the adequacy of insurer capital,  
11       surplus, reserves, or contributions, or

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

13       “(4) For additional provisions relating to association  
14       health plans, see subsections (a)(2)(B) and (b) of section  
15       805.

16       “(5) For purposes of this subsection, the term ‘asso-  
17       ciation health plan’ has the meaning provided in section  
18       801(a), and the terms ‘health insurance coverage’, ‘par-  
19       ticipating employer’, and ‘health insurance issuer’ have  
20       the meanings provided such terms in section 812, respec-  
21       tively.”.

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

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

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

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

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

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

16 (A) by striking “Nothing” and inserting  
17 “(1) Except as provided in paragraph (2), noth-  
18 ing”; and

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

21 “(2) Nothing in any other provision of law enacted  
22 on or after the date of the enactment of the Small Busi-  
23 ness Health Fairness Act of 2013 shall be construed to  
24 alter, amend, modify, invalidate, impair, or supersede any

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

3 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
4 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
5 the following new sentence: “Such term also includes a  
6 person serving as the sponsor of an association health plan  
7 under part 8.”.

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

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

19 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
20 CATION OF SELF-INSURED ASSOCIATION HEALTH  
21 PLANS.—Not later than January 1, 2016, the Secretary  
22 of Labor shall report to the Committee on Education and  
23 the Workforce of the House of Representatives and the  
24 Committee on Health, Education, Labor, and Pensions of

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

3 (g) CLERICAL AMENDMENT.—The table of contents  
4 in section 1 of the Employee Retirement Income Security  
5 Act of 1974 is amended by inserting after the item relat-  
6 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.”.

7 **SEC. 622. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
8 **PLOYER ARRANGEMENTS.**

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

12 (1) in clause (i), by inserting after “control  
13 group,” the following: “except that, in any case in  
14 which the benefit referred to in subparagraph (A)  
15 consists of medical care (as defined in section  
16 812(a)(2)), two or more trades or businesses, wheth-  
17 er or not incorporated, shall be deemed a single em-

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

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

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

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

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

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

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

17 **SEC. 623. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
18 **CIATION HEALTH PLANS.**

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

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

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

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

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

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

19               “(3) being a plan or arrangement described in  
20 section 3(40)(A)(i),

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

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

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

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

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

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

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



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

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

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

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

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

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

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

4 **SEC. 624. COOPERATION BETWEEN FEDERAL AND STATE**  
5 **AUTHORITIES.**

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

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

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

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

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

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

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

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

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

13 **SEC. 625. EFFECTIVE DATE AND TRANSITIONAL AND**  
14 **OTHER RULES.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 **CHAPTER 2—TARGETED EFFORTS TO**  
4 **EXPAND ACCESS**

5 **SEC. 631. EXTENDING COVERAGE OF DEPENDENTS.**

6 (a) EMPLOYEE RETIREMENT INCOME SECURITY ACT  
7 OF 1974.—

8 (1) IN GENERAL.—Part 7 of subtitle B of title  
9 I of the Employee Retirement Income Security Act  
10 of 1974 is amended by inserting after section 714  
11 the following new section:

12 **“SEC. 715. EXTENDING COVERAGE OF DEPENDENTS.**

13 “(a) IN GENERAL.—In the case of a group health  
14 plan, or health insurance coverage offered in connection  
15 with a group health plan, that treats as a beneficiary  
16 under the plan an individual who is a dependent child of  
17 a participant or beneficiary under the plan, the plan or  
18 coverage shall continue to treat the individual as a depend-  
19 ent child without regard to the individual’s age through  
20 at least the end of the plan year in which the individual  
21 turns an age specified in the plan, but not less than 23  
22 years of age.

23 “(b) CONSTRUCTION.—Nothing in this section shall  
24 be construed as requiring a group health plan to provide  
25 benefits for dependent children as beneficiaries under the

1 plan or to require a participant to elect coverage of de-  
2 pendent children.”.

3 (2) CLERICAL AMENDMENT.—The table of con-  
4 tents of such Act is amended by inserting after the  
5 item relating to section 714 the following new item:  
“Sec. 715. Extending coverage of dependents.”.

6 (b) PHSA.—Title XXVII of the Public Health Serv-  
7 ice Act is amended by inserting after section 2707 the fol-  
8 lowing new section:

9 **“SEC. 2708. EXTENDING COVERAGE OF DEPENDENTS.**

10 “(a) IN GENERAL.—In the case of a group health  
11 plan, or health insurance coverage offered in connection  
12 with a group health plan, that treats as a beneficiary  
13 under the plan an individual who is a dependent child of  
14 a participant or beneficiary under the plan, the plan or  
15 coverage shall continue to treat the individual as a depend-  
16 ent child without regard to the individual’s age through  
17 at least the end of the plan year in which the individual  
18 turns an age specified in the plan, but not less than 23  
19 years of age.

20 “(b) CONSTRUCTION.—Nothing in this section shall  
21 be construed as requiring a group health plan to provide  
22 benefits for dependent children as beneficiaries under the  
23 plan or to require a participant to elect coverage of de-  
24 pendent children.”.

25 (c) IRC.—

1           (1) IN GENERAL.—Subchapter B of chapter  
2           100 of the Internal Revenue Code of 1986 is amend-  
3           ed by adding at the end the following new section:

4   **“SEC. 9814. EXTENDING COVERAGE OF DEPENDENTS.**

5           “(a) IN GENERAL.—In the case of a group health  
6           plan that treats as a beneficiary under the plan an indi-  
7           vidual who is a dependent child of a participant or bene-  
8           ficiary under the plan, the plan shall continue to treat the  
9           individual as a dependent child without regard to the indi-  
10          vidual’s age through at least the end of the plan year in  
11          which the individual turns an age specified in the plan,  
12          but not less than 23 years of age.

13          “(b) CONSTRUCTION.—Nothing in this section shall  
14          be construed as requiring a group health plan to provide  
15          coverage for dependent children as beneficiaries under the  
16          plan or to require a participant to elect coverage of de-  
17          pendent children.”.

18          (2) CLERICAL AMENDMENT.—The table of sec-  
19          tions in such subchapter is amended by adding at  
20          the end the following new item:

“Sec. 9814. Extending coverage of dependents.”.

21          (d) EFFECTIVE DATE.—The amendments made by  
22          this section shall apply to group health plans for plan  
23          years beginning more than 3 months after the date of the  
24          enactment of this Act and shall apply to individuals who  
25          are dependent children under a group health plan, or



1 health insurance coverage offered in connection with such  
2 a plan, on or after such date.

3 **SEC. 632. ALLOWING AUTO-ENROLLMENT FOR EMPLOYER**  
4 **SPONSORED COVERAGE.**

5 (a) IN GENERAL.—No State shall establish a law  
6 that prevents an employer from instituting auto-enroll-  
7 ment for coverage of a participant or beneficiary, including  
8 current employees, under a group health plan, or health  
9 insurance coverage offered in connection with such a plan,  
10 so long as the participant or beneficiary has the option  
11 of declining such coverage.

12 (b) AUTO-ENROLLMENT.—

13 (1) NOTICE REQUIRED.—Employers with auto-  
14 enrollment under a group health plan or health in-  
15 surance coverage shall provide annual notification,  
16 within a reasonable period before the beginning of  
17 each plan year, to each employee eligible to partici-  
18 pate in the plan. The notice shall explain the em-  
19 ployee contribution to such plan and the employee's  
20 right to decline coverage.

21 (2) TREATMENT OF NON-ACTION.—After a rea-  
22 sonable period of time after receipt of the notice, if  
23 an employee fails to make an affirmative declaration  
24 declining coverage, then such an employee may be

1 enrolled in the group health plan or health insurance  
2 coverage offered in connection with such a plan.”.

3 (c) CONSTRUCTION.—Nothing in this section shall be  
4 construed to supersede State law which establishes, imple-  
5 ments, or continues in effect any standard or requirement  
6 relating to employers in connection with payroll or the  
7 sponsoring of employer sponsored health insurance cov-  
8 erage except to the extent that such standard or require-  
9 ment prevents an employer from instituting the auto-en-  
10 rollment described in subsection (a).

11 **TITLE VII—STOPPING MEDI-**  
12 **CARE, WASTE, FRAUD, AND**  
13 **ABUSE AND INCREASING PEN-**  
14 **ALTIES FOR ABUSERS**

15 **SEC. 701. INCREASED CIVIL MONEY PENALTIES AND CRIMI-**  
16 **NAL FINES FOR MEDICARE FRAUD AND**  
17 **ABUSE.**

18 (a) INCREASED CIVIL MONEY PENALTIES.—Section  
19 1128A of the Social Security Act (42 U.S.C. 1320a–7a)  
20 is amended—

21 (1) in subsection (a), in the matter following  
22 paragraph (10)—

23 (A) by striking “\$10,000” each place it  
24 appears and inserting “\$20,000”;

1 (B) by striking “\$15,000” and inserting  
2 “\$30,000”; and

3 (C) by striking “\$50,000” each place it ap-  
4 pears and inserting “\$100,000”; and  
5 (2) in subsection (b)—

6 (A) in paragraph (1), in the flush matter  
7 following subparagraph (B), by striking  
8 “\$2,000” and inserting “\$4,000”;

9 (B) in paragraph (2), by striking “\$2,000”  
10 and inserting “\$4,000”; and

11 (C) in paragraph (3)(A)(i), by striking  
12 “\$5,000” and inserting “\$10,000”.

13 (b) INCREASED CRIMINAL FINES.—Section 1128B of  
14 the Social Security Act (42 U.S.C. 1320a–7b) is amend-  
15 ed—

16 (1) in subsection (a), in the flush matter fol-  
17 lowing paragraph (6)—

18 (A) by striking “\$25,000” and inserting  
19 “\$100,000”; and

20 (B) by striking “\$10,000” and inserting  
21 “\$20,000”;

22 (2) in subsection (b)—

23 (A) in paragraph (1), in the flush matter  
24 following subparagraph (B), by striking  
25 “\$25,000” and inserting “\$100,000”; and

1 (B) in paragraph (2), in the flush matter  
2 following subparagraph (B), by striking  
3 “\$25,000” and inserting “\$100,000”;

4 (3) in subsection (c), by striking “\$25,000” and  
5 inserting “\$100,000”;

6 (4) in subsection (d), in the second flush matter  
7 following subparagraph (B), by striking “\$25,000”  
8 and inserting “\$100,000”; and

9 (5) in subsection (e), by striking “\$2,000” and  
10 inserting “\$4,000”.

11 (c) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to civil money penalties and fines  
13 imposed for actions taken on or after the date of enact-  
14 ment of this Act.

15 **SEC. 702. INCREASED SENTENCES FOR FELONIES INVOLV-**  
16 **ING MEDICARE FRAUD AND ABUSE.**

17 (a) FALSE STATEMENTS AND REPRESENTATIONS.—  
18 Section 1128B(a) of the Social Security Act (42 U.S.C.  
19 1320a–7b(a)) is amended, in clause (i) of the flush matter  
20 following paragraph (6), by striking “not more than five  
21 years” and inserting “not more than 10 years”.

22 (b) ANTI-KICKBACK.—Section 1128B(b) of the So-  
23 cial Security Act (42 U.S.C. 1320a–7b(b)) is amended—

24 (1) in paragraph (1), in the flush matter fol-  
25 lowing subparagraph (B), by striking “not more

1 than five years” and inserting “not more than 10  
2 years”; and

3 (2) in paragraph (2), in the flush matter fol-  
4 lowing subparagraph (B), by striking “not more  
5 than five years” and inserting “not more than 10  
6 years”.

7 (c) FALSE STATEMENT OR REPRESENTATION WITH  
8 RESPECT TO CONDITIONS OR OPERATIONS OF FACILI-  
9 TIES.—Section 1128B(c) of the Social Security Act (42  
10 U.S.C. 1320a–7b(c)) is amended by striking “not more  
11 than five years” and inserting “not more than 10 years”.

12 (d) EXCESS CHARGES.—Section 1128B(d) of the So-  
13 cial Security Act (42 U.S.C. 1320a–7b(d)) is amended, in  
14 the second flush matter following subparagraph (B), by  
15 striking “not more than five years” and inserting “not  
16 more than 10 years”.

17 (e) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to criminal penalties imposed for  
19 actions taken on or after the date of enactment of this  
20 Act.

21 **SEC. 703. OTHER DME SUPPLIER ANTI-FRAUD AND ABUSE**  
22 **PROVISIONS.**

23 (a) MANDATORY PERIODIC SITE INSPECTIONS FOR  
24 DME SUPPLIERS.—The Secretary of Health and Human  
25 Services shall require, as a condition for participation of

1 suppliers of durable medical equipment under part B of  
2 title XVIII of the Social Security Act—

3           (1) a site inspection to be conducted for each  
4           such supplier that has not previously participated  
5           under such part within 6 months of the date of its  
6           initial participation under such part; and

7           (2) a site inspection at least every 2 years to  
8           be conducted for each such supplier that has pre-  
9           viously participated under such part.

10          (b) POST-PAYMENT REVIEW.—The Secretary also  
11 shall provide conduct post-payment reviews of claims for  
12 items and services furnished under such part by durable  
13 medical equipment suppliers that begin participation  
14 under such part after the date of the enactment of this  
15 Act. Such reviews shall be conducted not less often than  
16 after the first 6, 12, and 18 months of such participation.

17          (c) AVAILABILITY OF FUNDS.—Funds in the Health  
18 Care Fraud and Abuse Control Account under section  
19 1817(k) of the Social Security Act (42 U.S.C. 1395i(k))  
20 shall be available for the conduct of site inspections and  
21 post-payment review required under this section.

22          (d) TREATMENT OF SKILLED NURSING FACILI-  
23 TIES.—In this section, a skilled nursing facility shall not  
24 be treated as a supplier of durable medical equipment with  
25 respect to any individual who is a resident of such facility.

1 **SEC. 704. RETENTION OF CERTAIN FRAUD AND ABUSE PRO-**  
2 **VISIONS.**

3 Section 101 shall not apply to the provisions (includ-  
4 ing amendments made by) title VI of Public Law 111-  
5 148, other than subtitles D, H, and I of such title, and  
6 provisions of Public Law 111-152 insofar as they relate  
7 to such provisions.

8 **SEC. 705. ENSURING TIMELY ENFORCEMENT OF MEDICARE**  
9 **SECONDARY PAYER REQUIREMENTS IN LI-**  
10 **ABILITY CASES.**

11 The Secretary of Health and Human Services, acting  
12 through the Administrator of the Centers for Medicare &  
13 Medicaid Services, shall affirmatively establish, for initial  
14 implementation not later than 90 days after the date of  
15 the enactment of this Act, a plan to require applicable  
16 plans (as defined in subparagraph (F) of section  
17 1862(b)(8) of the Social Security Act (42 U.S.C.  
18 1395y(b)(8)), as added by section 111(a) of the Medicare,  
19 Medicaid, and SCHIP Extension Act of 2007 (Public Law  
20 110-173)), to meet the determination and submission re-  
21 quirements under subparagraph (A) of such section  
22 1862(b)(8).

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