

114TH CONGRESS
1ST SESSION

H. R. 2300

To provide for incentives to encourage health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 13, 2015

Mr. TOM PRICE of Georgia (for himself, Mr. HENSARLING, Mrs. BLACKBURN, Mr. HARRIS, Mr. BENISHEK, Mrs. ELLMERS of North Carolina, Mr. BUCSHON, Mr. PITTENGER, Mr. MEADOWS, Mr. DUNCAN of South Carolina, Mr. MCKINLEY, Mr. THOMPSON of Pennsylvania, Mr. FRANKS of Arizona, Mr. TIPTON, Mr. WEBSTER of Florida, Mr. WESTMORELAND, Mr. RIGELL, Mr. LAMBORN, Mr. HUIZENGA of Michigan, Mr. OLSON, Mr. PERRY, Mr. YOHO, Mr. AMODEI, Mr. ROTHFUS, Mr. STEWART, Mr. ROUZER, Mr. GUINTA, Mrs. BLACK, Mr. JENKINS of West Virginia, Mr. DESJARLAIS, Mrs. HARTZLER, Mr. HECK of Nevada, Mr. MILLER of Florida, Mr. MULVANEY, Mr. RIBBLE, Mr. RICE of South Carolina, Mr. ROE of Tennessee, Mr. ROSKAM, Mr. WENSTRUP, Mr. WILSON of South Carolina, Mr. WOODALL, Mr. YODER, Mr. PEARCE, Mr. HARPER, Mr. McCLINTOCK, Mr. GOWDY, and Mr. GOODLATTE) 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, Appropriations, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for incentives to encourage health insurance coverage, 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 “Empowering Patients First Act of 2015”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Repeal of PPACA and health care-related HCERA provisions.
- Sec. 3. No mandate of guaranteed issue or community rating.

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH
INSURANCE COVERAGE

Subtitle A—Tax Credit for Health Insurance Coverage

- Sec. 101. Refundable tax credit for health insurance coverage.
- Sec. 102. Election of tax credit instead of alternative government or group plan benefits.

Subtitle B—Health Savings Accounts

- Sec. 111. Refundable tax credit for health savings account contributions.
- Sec. 112. Allowing HSA rollover to child or parent of account holder.
- Sec. 113. Maximum contribution limit to HSA coordinated with retirement savings account limitation.
- Sec. 114. Transfer of required minimum distribution from retirement plan to health savings account.
- Sec. 115. Equivalent bankruptcy protections for health savings accounts as retirement funds.
- Sec. 116. Allow both spouses to make catch-up contributions to the same HSA account.
- Sec. 117. Provisions relating to Medicare.
- Sec. 118. Individuals eligible for veterans benefits for a service-connected disability.
- Sec. 119. Individuals eligible for Indian Health Service assistance.
- Sec. 120. Individuals eligible for TRICARE coverage.
- Sec. 121. FSA and HRA interaction with HSAs.
- Sec. 122. Special rule for certain medical expenses incurred before establishment of account.
- Sec. 123. Preventive care prescription drug clarification.
- Sec. 124. Administrative error correction before due date of return.
- Sec. 125. Members of health care sharing ministries eligible to establish health savings accounts.
- Sec. 126. High deductible health plans renamed HSA qualified plans.
- Sec. 127. Treatment of direct primary care service arrangements.
- Sec. 128. Certain provider fees to be treated as medical care.

Sec. 129. Clarification of treatment of capitated primary care payments as amounts paid for medical care.

Subtitle C—Other Provisions

Sec. 131. Limitation on employer-provided health care coverage.
 Sec. 132. Limitation on abortion funding.
 Sec. 133. No government discrimination against certain health care entities.
 Sec. 134. Equal employer contribution rule to promote choice.
 Sec. 135. Limitations on State restrictions on employer auto-enrollment.
 Sec. 136. Credit for small employers adopting auto-enrollment and defined contribution options.

TITLE II—HEALTH CARE ACCESS AND AVAILABILITY

Subtitle A—Health Insurance Pooling Mechanisms for Individuals

Sec. 201. Federal grants for State insurance expenditures.
 Sec. 202. Pool reform for individual membership expansion.

Subtitle B—Small Business Health Fairness

Sec. 211. Short title.
 Sec. 212. Rules governing association health plans.
 Sec. 213. Clarification of treatment of single employer arrangements.
 Sec. 214. Enforcement provisions relating to association health plans.
 Sec. 215. Cooperation between Federal and State authorities.
 Sec. 216. Effective date and transitional and other rules.

Subtitle C—Health Insurance Reforms

Sec. 221. Requirements for individual health insurance.

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

Sec. 301. Cooperative governing of individual health insurance coverage.

TITLE IV—LAWSUIT ABUSE REFORMS

Sec. 401. Change in burden of proof based on compliance with clinical practice guidelines.
 Sec. 402. State grants to create expert panels and administrative health care tribunals.
 Sec. 403. Payment of damages and recovery of costs in health care lawsuits.
 Sec. 404. Definitions.
 Sec. 405. Effect on other laws.
 Sec. 406. Applicability; effective date.

TITLE V—WELLNESS AND PREVENTION

Sec. 501. Providing financial incentives for treatment compliance.

TITLE VI—TRANSPARENCY AND INSURANCE REFORM MEASURES

Sec. 601. Receipt and response to requests for claim information.

TITLE VII—QUALITY

Sec. 701. Prohibition on certain uses of data obtained from comparative effectiveness research or from patient-centered outcomes research; accounting for personalized medicine and differences in patient treatment response.

Sec. 702. Establishment of performance-based quality measures.

TITLE VIII—STATE TRANSPARENCY PLAN PORTAL

Sec. 801. Providing information on health coverage options and health care providers.

TITLE IX—PATIENT FREEDOM OF CHOICE

Sec. 901. Guaranteeing freedom of choice and contracting for patients under Medicare.

Sec. 902. Preemption of State laws limiting charges for eligible professional services.

Sec. 903. Health care provider licensure cannot be conditioned on participation in a health plan.

Sec. 904. Bad debt deduction for doctors to partially offset the cost of providing uncompensated care required to be provided under amendments made by the Emergency Medical Treatment and Labor Act.

Sec. 905. Right of contract with health care providers.

TITLE X—QUALITY HEALTH CARE COALITION

Sec. 1001. Quality Health Care Coalition.

1 **SEC. 2. REPEAL OF PPACA AND HEALTH CARE-RELATED** 2 **HCERA PROVISIONS.**

3 (a) PPACA.—Effective as of the enactment of the
 4 Patient Protection and Affordable Care Act (Public Law
 5 111–148), such Act is repealed, and the provisions of law
 6 amended or repealed by such Act are restored or revived
 7 as if such Act had not been enacted.

8 (b) HEALTH CARE-RELATED PROVISIONS IN THE
 9 HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
 10 2010.—Effective as of the enactment of the Health Care
 11 and Education Reconciliation Act of 2010 (Public Law
 12 111–152), title I and subtitle B of title II of such Act
 13 are repealed, and the provisions of law amended or re-

1 pealed by such title or subtitle, respectively, are restored
 2 or revived as if such title and subtitle had not been en-
 3 acted.

4 **SEC. 3. NO MANDATE OF GUARANTEED ISSUE OR COMMU-**
 5 **NITY RATING.**

6 Nothing in this Act shall be construed to provide a
 7 mandate for guaranteed issue or community rating in the
 8 private insurance market.

9 **TITLE I—TAX INCENTIVES FOR**
 10 **MAINTAINING HEALTH IN-**
 11 **SURANCE COVERAGE**

12 **Subtitle A—Tax Credit for Health**
 13 **Insurance Coverage**

14 **SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSUR-**
 15 **ANCE COVERAGE.**

16 (a) IN GENERAL.—Subpart C of part IV of sub-
 17 chapter A of chapter 1 of the Internal Revenue Code of
 18 1986, as amended by section 2, is amended by inserting
 19 after section 36A the following new section:

20 **“SEC. 36B. HEALTH INSURANCE COVERAGE.**

21 “(a) IN GENERAL.—In the case of an individual,
 22 there shall be allowed as a credit against the tax imposed
 23 by subtitle A the aggregate monthly credit amounts deter-
 24 mined under subsection (b) with respect to the taxpayer

1 and the taxpayer's qualifying family members for eligible
2 coverage months beginning during the taxable year.

3 “(b) MONTHLY CREDIT AMOUNTS.—

4 “(1) IN GENERAL.—The monthly credit amount
5 with respect to any individual for any eligible cov-
6 erage month is $\frac{1}{12}$ of—

7 “(A) \$900 in the case of an individual who
8 has not attained age 18 as of the beginning of
9 such month,

10 “(B) \$1,200 in the case of an individual
11 who has so attained age 18 but who has not so
12 attained age 35,

13 “(C) \$2,100 in the case of an individual
14 who has so attained age 35, but who has not
15 so attained age 50, and

16 “(D) \$3,000 in the case of an individual
17 who has so attained age 50.

18 “(2) INFLATION ADJUSTMENT.—In the case of
19 any taxable year beginning in a calendar year after
20 2016, each dollar amount contained in paragraph
21 (1) shall be increased by an amount equal to—

22 “(A) such dollar amount, multiplied by

23 “(B) the cost-of-living adjustment deter-
24 mined under section 1(f)(3) for the calendar
25 year in which the taxable year begins, deter-

1 mined by substituting ‘calendar year 2015’ for
2 ‘calendar year 1992’ in subparagraph (B)
3 thereof.

4 Any increase determined under the preceding sen-
5 tence shall be rounded to the nearest multiple of
6 \$50.

7 “(c) ELIGIBLE COVERAGE MONTH.—For purposes of
8 this section, the term ‘eligible coverage month’ means,
9 with respect to any individual, any month if, as of the first
10 day of such month, the individual—

11 “(1) is covered by qualified health insurance,

12 “(2) does not have other specified coverage, and

13 “(3) is not imprisoned under Federal, State, or
14 local authority.

15 “(d) QUALIFYING FAMILY MEMBER.—For purposes
16 of this section, the term ‘qualifying family member’
17 means—

18 “(1) in the case of a joint return, the taxpayer’s
19 spouse, and

20 “(2) any dependent of the taxpayer.

21 “(e) QUALIFIED HEALTH INSURANCE.—For pur-
22 poses of this section, the term ‘qualified health insurance’
23 means health insurance coverage (other than excepted
24 benefits as defined in section 9832(c)) which constitutes
25 medical care.

1 “(f) OTHER SPECIFIED COVERAGE.—For purposes of
2 this section, an individual has other specified coverage for
3 any month if, as of the first day of such month—

4 “(1) COVERAGE UNDER MEDICARE, MEDICAID,
5 OR SCHIP.—Such individual—

6 “(A) is entitled to benefits under part A of
7 title XVIII of the Social Security Act or is en-
8 rolled under part B of such title, or

9 “(B) is enrolled in the program under title
10 XIX or XXI of such Act (other than under sec-
11 tion 1928 of such Act).

12 “(2) CERTAIN OTHER COVERAGE.—Such indi-
13 vidual—

14 “(A) is enrolled in a health benefits plan
15 under chapter 89 of title 5, United States Code,

16 “(B) is entitled to receive benefits under
17 chapter 55 of title 10, United States Code,

18 “(C) is entitled to receive benefits under
19 chapter 17 of title 38, United States Code,

20 “(D) is enrolled in a group health plan
21 (within the meaning of section 5000(b)(1))
22 which is subsidized by the employer, or

23 “(E) is a member of a health care sharing
24 ministry.

1 “(3) HEALTH CARE SHARING MINISTRY.—For
2 purposes of this subsection, the term ‘health care
3 sharing ministry’ means an organization—

4 “(A) which is described in section
5 501(c)(3) and is exempt from taxation under
6 section 501(a),

7 “(B) members of which share a common
8 set of ethical or religious beliefs and share med-
9 ical expenses among members in accordance
10 with those beliefs and without regard to the
11 State in which a member resides or is em-
12 ployed,

13 “(C) members of which retain membership
14 even after they develop a medical condition,

15 “(D) which (or a predecessor of which) has
16 been in existence at all times since December
17 31, 1999, and medical expenses of its members
18 have been shared continuously and without
19 interruption since at least December 31, 1999,
20 and

21 “(E) which conducts an annual audit
22 which is performed by an independent certified
23 public accounting firm in accordance with gen-
24 erally accepted accounting principles and which
25 is made available to the public upon request.

1 “(g) SPECIAL RULES.—

2 “(1) CREDIT IN EXCESS OF PREMIUMS ONLY
3 PAYABLE TO A HEALTH SAVINGS ACCOUNT.—

4 “(A) IN GENERAL.—If the credit allowed
5 under subsection (a) (determined without re-
6 gard to clause (ii)) for any taxable year exceeds
7 the amount of premiums paid by the taxpayer
8 for coverage of the taxpayer and the taxpayer’s
9 qualifying family members under qualified
10 health insurance for eligible coverage months
11 beginning in the taxable year—

12 “(i) at the request of the taxpayer,
13 the Secretary shall pay the amount of such
14 excess to one or more health savings ac-
15 counts of the taxpayer or of any qualifying
16 family member of the taxpayer, and

17 “(ii) the credit allowed under sub-
18 section (a) for such taxable year shall not
19 exceed the amount of such premiums.

20 “(B) MEDICAL AND HEALTH SAVINGS AC-
21 COUNTS.—Amounts distributed from an Archer
22 MSA (as defined in section 220(d)) or from a
23 health savings account (as defined in section
24 223(d)) shall not be taken into account as pre-
25 miums paid under subparagraph (A).

1 “(C) INSURANCE WHICH COVERS OTHER
2 INDIVIDUALS.—For purposes of this paragraph,
3 rules similar to the rules of section 213(d)(6)
4 shall apply with respect to any contract for
5 qualified health insurance under which amounts
6 are payable for coverage of an individual other
7 than the taxpayer and qualifying family mem-
8 bers.

9 “(D) CONTRIBUTIONS TREATED AS ROLL-
10 OVERS, ETC.—

11 “(i) IN GENERAL.—Any amount paid
12 the Secretary to a health savings account
13 under this paragraph shall be treated for
14 purposes of this title in the same manner
15 as a rollover contribution described in sec-
16 tion 223(f)(5).

17 “(ii) COORDINATION WITH LIMITA-
18 TION ON ROLLOVERS.—Any amount de-
19 scribed in clause (i) shall not be taken into
20 account in applying section 223(f)(5)(B)
21 with respect to any other amount and the
22 limitation of section 223(f)(5)(B) shall not
23 apply with respect to the application of
24 clause (i).

1 “(iii) ESTABLISHMENT OF HSAS.—
2 Nothing in any provision of law shall be
3 construed—

4 “(I) to prevent an individual
5 from establishing a health savings ac-
6 count (as defined in section 223(d))
7 merely because such individual is not
8 an eligible individual (as defined in
9 section 223(e)), or

10 “(II) to prevent such an account
11 from being treated as a health savings
12 account merely because all or a sub-
13 stantial portion of the contributions to
14 such account are described in this
15 paragraph.

16 “(2) COORDINATION WITH ADVANCE PAYMENTS
17 OF CREDIT.—With respect to any taxable year—

18 “(A) the amount which would (but for this
19 subsection) be allowed as a credit to the tax-
20 payer under subsection (a) shall be reduced
21 (but not below zero) by the aggregate amount
22 paid on behalf of such taxpayer under section
23 7529 for months beginning in such taxable
24 year, and

1 “(B) the tax imposed by section 1 for such
2 taxable year shall be increased by the excess (if
3 any) of—

4 “(i) the aggregate amount paid on be-
5 half of such taxpayer under section 7529
6 for months beginning in such taxable year,
7 over

8 “(ii) the amount which would (but for
9 this subsection) be allowed as a credit to
10 the taxpayer under subsection (a).

11 “(3) COORDINATION WITH OTHER PROVI-
12 SIONS.—For purposes of any deduction allowed
13 under section 162(l), 213, or 224, and any credit al-
14 lowed under section 35, any health insurance pre-
15 miums which would (but for this paragraph) be
16 taken into account shall be reduced (but not below
17 zero) by the amount of the credit allowed under this
18 section (determined without regard to paragraphs
19 (1) and (2) of this subsection).

20 “(4) DENIAL OF CREDIT TO DEPENDENTS AND
21 NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—
22 No credit shall be allowed under this section to any
23 individual who is—

1 “(A) not a citizen or lawful permanent
2 resident of the United States for the calendar
3 year in which the taxable year begins, or

4 “(B) a dependent with respect to another
5 taxpayer for a taxable year beginning in the
6 calendar year in which such individual’s taxable
7 year begins.

8 “(5) REGULATIONS.—The Secretary may pre-
9 scribe such regulations and other guidance as may
10 be necessary or appropriate to carry out this section,
11 section 6050W, and section 7529.”.

12 (b) ADVANCE PAYMENT OF CREDIT.—

13 (1) IN GENERAL.—Chapter 77 of the Internal
14 Revenue Code of 1986 (relating to miscellaneous
15 provisions) is amended by adding at the end the fol-
16 lowing:

17 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
18 **INSURANCE COVERAGE.**

19 “(a) GENERAL RULE.—Not later than January 1,
20 2016, the Secretary shall establish a program for making
21 payments to providers of qualified health insurance (as de-
22 fined in section 36B(e)) on behalf of taxpayers eligible for
23 the credit under section 36B.

24 “(b) LIMITATION.—The aggregate payments made
25 under this section with respect to any taxpayer, deter-

1 mined as of any time during any calendar year, shall not
2 exceed the monthly credit amounts determined with re-
3 spect to such taxpayer under section 36B for months dur-
4 ing such calendar year which have ended as of such time.

5 “(c) APPLICATION OF RULE THAT CREDITS IN EX-
6 CESS OF PREMIUMS ONLY PAYABLE TO A HEALTH SAV-
7 INGS ACCOUNT.—Under rules similar to the rules of sec-
8 tion 36B(g)(1), any amount otherwise payable on behalf
9 of the taxpayer under subsection (a) with respect to any
10 eligible coverage month which is in excess of the amount
11 of premiums paid by the taxpayer for coverage of the tax-
12 payer and the taxpayer’s qualifying family members under
13 qualified health insurance for such month shall be payable
14 only to one or more health savings accounts of the tax-
15 payer or of any qualifying family member of the taxpayer.

16 “(d) CERTIFICATION PROCESS AND PROOF OF COV-
17 ERAGE.—The Secretary shall establish a process under
18 which individuals are certified as eligible for payment
19 under this section. Such process shall include an initial
20 application by the taxpayer to determine eligibility and
21 thereafter continued eligibility shall be determined, to the
22 maximum extent feasible, by the Secretary on the basis
23 of information provided under section 6050X.

24 “(e) DEFINITIONS.—For purposes of this section,
25 terms used in this section which are also used in section

1 36B shall have the same meaning as when used in section
2 36B.”.

3 (2) INFORMATION REPORTING.—

4 (A) IN GENERAL.—Subpart B of part III
5 of subchapter A of chapter 61 of such Code (re-
6 lating to information concerning transactions
7 with other persons) is amended by adding at
8 the end the following new section:

9 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH**
10 **INSURANCE COVERAGE.**

11 “(a) REQUIREMENT OF REPORTING.—Every person
12 who provides qualified health insurance for any month of
13 any calendar year with respect to any individual shall, at
14 such time as the Secretary may prescribe, make the return
15 described in subsection (b) with respect to each such indi-
16 vidual. With respect to any individual with respect to
17 whom payments under section 7529 are made by the Sec-
18 retary, the Secretary may require that reporting under
19 subsection (b) be made on a monthly basis.

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

22 “(1) is in such form as the Secretary may pre-
23 scribe, and

24 “(2) contains, with respect to each policy of
25 qualified health insurance—

1 “(A) the name, address, and TIN of each
2 individual covered under such policy,

3 “(B) the premiums paid with respect to
4 such policy, and

5 “(C) such other information as the Sec-
6 retary may prescribe.

7 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
8 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
9 QUIRED.—Every person required to make a return under
10 subsection (a) shall furnish to each individual whose name
11 is required to be set forth in such return a written state-
12 ment showing—

13 “(1) the name and address of the person re-
14 quired to make such return and the phone number
15 of the information contact for such person, and

16 “(2) the information required to be shown on
17 the return with respect to such individual.

18 The written statement required under the preceding sen-
19 tence shall be furnished on or before January 31 of the
20 year following the calendar year to which such statement
21 relates.

22 “(d) DEFINITIONS.—For purposes of this section,
23 terms used in this section which are also used in section
24 36B shall have the same meaning as when used in section
25 36B.”.

1 (B) ASSESSABLE PENALTIES.—

2 (i) Subparagraph (B) of section
3 6724(d)(1) of such Code, as amended by
4 section 2, is amended by striking “or” at
5 the end of clause (xxii), by striking “and”
6 at the end of clause (xxiii) and inserting
7 “or”, and by inserting after clause (xxiii)
8 the following new clause:

9 “(xxiv) section 6050X (relating to re-
10 turns relating to credit for health insur-
11 ance coverage), and”.

12 (ii) Paragraph (2) of section 6724(d)
13 of such Code, as amended by section 2, is
14 amended by striking “or” at the end of
15 subparagraph (EE), by striking the period
16 at the end of subparagraph (FF) and in-
17 serting “, or”, and by adding after sub-
18 paragraph (FF) the following new sub-
19 paragraph:

20 “(GG) section 6050X (relating to returns
21 relating to credit for health insurance cov-
22 erage).”.

23 (3) DISCLOSURE OF RETURN INFORMATION
24 FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT

1 AS PREMIUMS FOR QUALIFIED HEALTH INSUR-
2 ANCE.—

3 (A) IN GENERAL.—Subsection (l) of sec-
4 tion 6103 of such Code, as amended by section
5 2, is amended by adding at the end the fol-
6 lowing new paragraph:

7 “(21) DISCLOSURE OF RETURN INFORMATION
8 RELATED TO PAYMENTS OF THE HEALTH INSUR-
9 ANCE COVERAGE CREDIT.—The Secretary may, on
10 behalf of taxpayers eligible for the credit under sec-
11 tion 36B, disclose to a provider of qualified health
12 insurance (as defined in section 36(e)) or a trustee
13 of a health savings account (and persons acting on
14 behalf of such provider or such trustee), return in-
15 formation with respect to any such taxpayer only to
16 the extent necessary (as prescribed by regulations
17 issued by the Secretary) to carry out sections
18 36B(g)(1) (relating to credit in excess of premiums
19 only payable to a health savings account) and 7529
20 (relating to advance payment of credit for health in-
21 surance coverage).”.

22 (B) CONFIDENTIALITY OF INFORMA-
23 TION.—Paragraph (3) of section 6103(a) of
24 such Code, as amended by section 2, is amend-

1 ed by striking “or (20)” and inserting “(20), or
2 (21)”.

3 (C) UNAUTHORIZED DISCLOSURE.—Para-
4 graph (2) of section 7213(a) of such Code, as
5 amended by section 2, is amended by striking
6 “or (20)” and inserting “(20), or (21)”.

7 (4) EFFECTIVE DATE.—The amendments made
8 by this section shall take effect on the date of the
9 enactment of this Act.

10 (c) CONFORMING AMENDMENTS.—

11 (1) Paragraph (2) of section 1324(b) of title
12 31, United States Code, as amended by section 2, is
13 amended by inserting “36B,” after “36A,”.

14 (2) The table of sections for subpart C of part
15 IV of subchapter A of chapter 1 of the Internal Rev-
16 enue Code of 1986, as amended by section 2, is
17 amended by inserting after the item relating to sec-
18 tion 36A the following new item:

“Sec. 36B. Health insurance coverage.”.

19 (3) The table of sections for subpart B of part
20 III of subchapter A of chapter 61 of such Code is
21 amended by adding at the end the following new
22 item:

“Sec. 6050X. Returns relating to credit for health insurance coverage.”.

1 (4) The table of sections for chapter 77 of such
2 Code is amended by adding at the end the following
3 new item:

“Sec. 7529. Advance payment of credit for health insurance coverage.”.

4 (d) **EFFECTIVE DATE.**—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2015.

7 **SEC. 102. ELECTION OF TAX CREDIT INSTEAD OF ALTER-**
8 **NATIVE GOVERNMENT OR GROUP PLAN BEN-**
9 **EFITS.**

10 (a) **IN GENERAL.**—Notwithstanding any other provi-
11 sion of law, an individual who is otherwise eligible for ben-
12 efits under a health program (as defined in subsection (e))
13 may elect, in a form and manner specified by the Sec-
14 retary of Health and Human Services in consultation with
15 the Secretary of the Treasury, to receive a tax credit de-
16 scribed in section 36B of the Internal Revenue Code of
17 1986 (which may be used for the purpose of health insur-
18 ance coverage) in lieu of receiving any benefits under such
19 program.

20 (b) **EFFECTIVE DATE.**—An election under subsection
21 (a) may first be made for calendar year 2016 and any
22 such election shall be effective for such period (not less
23 than one calendar year) as the Secretary of Health and
24 Human Services shall specify, in consultation with the
25 Secretary of the Treasury.

1 (c) HEALTH PROGRAM DEFINED.—For purposes of
2 this section, the term “health program” means any of the
3 following:

4 (1) MEDICARE.—The Medicare program under
5 part A of title XVIII of the Social Security Act.

6 (2) MEDICAID.—The Medicaid program under
7 title XIX of such Act (including such a program op-
8 erating under a Statewide waiver under section 1115
9 of such Act).

10 (3) SCHIP.—The State children’s health insur-
11 ance program under title XXI of such Act.

12 (4) TRICARE.—The TRICARE program
13 under chapter 55 of title 10, United States Code.

14 (5) VETERANS BENEFITS.—Coverage for bene-
15 fits under chapter 17 of title 38, United States
16 Code.

17 (6) FEHBP.—Coverage under chapter 89 of
18 title 5, United States Code.

19 (7) SUBSIDIZED GROUP HEALTH PLANS.—Cov-
20 erage under a group health plan (within the meaning
21 of section 5000(b)(1)) which is subsidized by the
22 employer.

23 (d) OTHER SOCIAL SECURITY BENEFITS NOT
24 WAIVED.—An election to waive the benefits described in

1 subsection (e)(1) shall not result in the waiver of any other
2 benefits under the Social Security Act.

3 **Subtitle B—Health Savings** 4 **Accounts**

5 **SEC. 111. REFUNDABLE TAX CREDIT FOR HEALTH SAVINGS** 6 **ACCOUNT CONTRIBUTIONS.**

7 (a) IN GENERAL.—Subpart C of part IV of sub-
8 chapter A of chapter 1 of the Internal Revenue Code of
9 1986, as amended by the preceding provisions of this Act,
10 is amended by inserting after section 36B the following
11 new section:

12 **“SEC. 36C. HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.**

13 “(a) IN GENERAL.—In the case of an individual who
14 is allowed a deduction under section 223(a) for any tax-
15 able year, there shall be allowed as a credit against the
16 tax imposed by subtitle A for such taxable year, the lesser
17 of—

18 “(1) the amount so allowed as a deduction, or

19 “(2) \$1,000.

20 “(b) LIFETIME LIMITATION.—The credit allowed
21 under subsection (a) with respect to any individual shall
22 not exceed the excess (if any) of \$1,000 over the aggregate
23 credits allowed with respect to such individual under sub-
24 section (a) for all prior taxable years.”.

25 (b) CONFORMING AMENDMENTS.—

1 (1) Paragraph (2) of section 1324(b) of title
2 31, United States Code, as amended by the pre-
3 ceding provisions of this Act, is amended by insert-
4 ing “36B,” after “36A,”.

5 (2) The table of sections for subpart C of part
6 IV of subchapter A of chapter 1 of the Internal Rev-
7 enue Code of 1986, as amended by the preceding
8 provisions of this Act, is amended by inserting after
9 the item relating to section 36A the following new
10 item:

“Sec. 36B. Health insurance coverage.”.

11 (c) CONFORMING AMENDMENTS.—

12 (1) Paragraph (2) of section 1324(b) of title
13 31, United States Code, as amended by the pre-
14 ceding provisions of this Act, is amended by insert-
15 ing “36C,” after “36B,”.

16 (2) The table of sections for subpart C of part
17 IV of subchapter A of chapter 1 of the Internal Rev-
18 enue Code of 1986, as amended by the preceding
19 provisions of this Act, is amended by inserting after
20 the item relating to section 36B the following new
21 item:

“Sec. 36C. Health savings account contributions.”.

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

1 **SEC. 112. ALLOWING HSA ROLLOVER TO CHILD OR PARENT**
2 **OF ACCOUNT HOLDER.**

3 (a) IN GENERAL.—Section 223(f)(8)(A) of the Inter-
4 nal Revenue Code of 1986 is amended—

5 (1) by inserting “child, parent, or grandparent”
6 after “surviving spouse”,

7 (2) by inserting “child, parent, or grandparent,
8 as the case may be,” after “the spouse”,

9 (3) by inserting “, CHILD, PARENT, OR GRAND-
10 PARENT” after “SPOUSE” in the heading thereof,
11 and

12 (4) by adding at the end the following: “In the
13 case of a child who acquires such beneficiary’s inter-
14 est and with respect to whom a deduction under sec-
15 tion 151 is allowable to another taxpayer for a tax-
16 able year beginning in the calendar year in which
17 such individual’s taxable year begins, such health
18 savings account shall be treated as a child health
19 savings account of the child.”.

20 (b) 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. 113. MAXIMUM CONTRIBUTION LIMIT TO HSA COORDI-**
2 **NATED WITH RETIREMENT SAVINGS AC-**
3 **COUNT LIMITATION.**

4 (a) **SELF-ONLY COVERAGE.**—Section 223(b)(2)(A)
5 of the Internal Revenue Code of 1986 is amended by strik-
6 ing “\$2,250” and inserting “the amount in effect under
7 section 219(b)(5)(A)”.

8 (b) **FAMILY COVERAGE.**—Section 223(b)(2)(B) of
9 such Code is amended by striking “\$4,500” and inserting
10 “twice the amount in effect under subparagraph (A)”.

11 (c) **CONFORMING AMENDMENTS.**—Section 223(g)(1)
12 of such Code is amended—

13 (1) in the matter preceding subparagraph (A),
14 by striking “subsections (b)(2) and (c)(2)(A)” and
15 inserting “subsection (c)(2)(A)”,

16 (2) in subparagraph (B), by striking “by sub-
17 stituting” and all that follows through the end of
18 clause (ii) and inserting “by substituting ‘calendar
19 year 2003’ for ‘calendar year 1992’ in subparagraph
20 (B) thereof.”, and

21 (3) in the matter following subparagraph (B),
22 by striking “subsections (b)(2) and (c)(2)(A)” and
23 inserting “subsection (c)(2)(A)”.

24 (d) **EFFECTIVE DATE.**—The amendments made by
25 this section shall apply to taxable years beginning after
26 the date of the enactment of this Act.

1 **SEC. 114. TRANSFER OF REQUIRED MINIMUM DISTRIBUTION FROM RETIREMENT PLAN TO HEALTH**
2 **SAVINGS ACCOUNT.**
3

4 (a) TRANSFER FROM RETIREMENT PLAN.—

5 (1) INDIVIDUAL RETIREMENT ACCOUNTS.—Section
6 tion 408(d) of the Internal Revenue Code of 1986
7 is amended by adding at the end the following new
8 paragraph:

9 “(10) REQUIRED MINIMUM DISTRIBUTION
10 TRANSFERRED TO HEALTH SAVINGS ACCOUNT.—

11 “(A) IN GENERAL.—In the case of an indi-
12 vidual who has attained the age of 70½ and
13 who elects the application of this paragraph for
14 a taxable year, gross income of the individual
15 for the taxable year does not include a qualified
16 HSA transfer to the extent such transfer is oth-
17 erwise includible in gross income.

18 “(B) QUALIFIED HSA TRANSFER.—For
19 purposes of this paragraph, the term ‘qualified
20 HSA transfer’ means any distribution from an
21 individual retirement plan—

22 “(i) to a health savings account of the
23 individual in a direct trustee-to-trustee
24 transfer,

25 “(ii) to the extent such distribution
26 does not exceed the required minimum dis-

1 tribution determined under section
2 401(a)(9) for the distribution calendar
3 year ending during the taxable year.

4 “(C) APPLICATION OF SECTION 72.—Not-
5 withstanding section 72, in determining the ex-
6 tent to which an amount is treated as otherwise
7 includible in gross for purposes of subparagraph
8 (A), the aggregate amount distributed from an
9 individual retirement plan shall be treated as
10 includible in gross income to the extent that
11 such amount does not exceed the aggregate
12 amount which would have been so includible if
13 all amounts from all individual retirement plans
14 were distributed. Proper adjustments shall be
15 made in applying section 72 to other distribu-
16 tions in such taxable year and subsequent tax-
17 able years.

18 “(D) COORDINATION.—An election may
19 not be made under subparagraph (A) for a tax-
20 able year for which an election is in effect
21 under paragraph (9).”.

22 (2) OTHER RETIREMENT PLANS.—Section 402
23 of such Code is amended by adding at the end the
24 following new subsection:

1 “(m) REQUIRED MINIMUM DISTRIBUTION TRANS-
2 FERRED TO HEALTH SAVINGS ACCOUNT.—

3 “(1) IN GENERAL.—In the case of an individual
4 who has attained the age of 70½ and who elects the
5 application of this subsection for a taxable year,
6 gross income of the individual for the taxable year
7 does not include a qualified HSA transfer to the ex-
8 tent such transfer is otherwise includible in gross in-
9 come.

10 “(2) QUALIFIED HSA TRANSFER.—For pur-
11 poses of this subsection, the term ‘qualified HSA
12 transfer’ means any distribution from a retirement
13 plan—

14 “(A) to a health savings account of the in-
15 dividual in a direct trustee-to-trustee transfer,

16 “(B) to the extent such distribution does
17 not exceed the required minimum distribution
18 determined under section 401(a)(9) for the dis-
19 tribution calendar year ending during the tax-
20 able year.

21 “(3) APPLICATION OF SECTION 72.—Notwith-
22 standing section 72, in determining the extent to
23 which an amount is treated as otherwise includible
24 in gross for purposes of paragraph (1), the aggre-
25 gate amount distributed from an individual retire-

1 ment plan shall be treated as includible in gross in-
2 come to the extent that such amount does not exceed
3 the aggregate amount which would have been so in-
4 cludible if all amounts from all individual retirement
5 plans were distributed. Proper adjustments shall be
6 made in applying section 72 to other distributions in
7 such taxable year and subsequent taxable years.

8 “(4) ELIGIBLE RETIREMENT PLAN.—For pur-
9 poses of this subsection, the term ‘eligible retirement
10 plan’ has the meaning given such term by subsection
11 (c)(8)(B) (determined without regard to clauses (i)
12 and (ii) thereof).”.

13 (b) TRANSFER TO HEALTH SAVINGS ACCOUNT.—

14 (1) IN GENERAL.—Section 223(d)(1)(A) of
15 such Code is amended by striking “or” at the end
16 of clause (i), by striking the period at the end of
17 clause (ii)(II) and inserting “, or”, and by adding at
18 the end the following new clause:

19 “(iii) unless it is in a qualified HSA
20 transfer described in section 408(d)(10) or
21 402(m).”.

22 (2) EXCISE TAX INAPPLICABLE TO QUALIFIED
23 HSA TRANSFER.—Section 4973(g)(1) of such Code
24 is amended by inserting “or in a qualified HSA

1 transfer described in section 408(d)(10) or 402(m)”
2 after “or 223(f)(5)”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to distributions made after the
5 date of the enactment of this Act.

6 **SEC. 115. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**
7 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**
8 **MENT FUNDS.**

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

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

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

1 **SEC. 116. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**
 2 **TRIBUTIONS TO THE SAME HSA ACCOUNT.**

3 (a) IN GENERAL.—Section 223(b)(3) of the Internal
 4 Revenue Code of 1986 is amended by adding at the end
 5 the following new subparagraph:

6 “(C) SPECIAL RULE WHERE BOTH
 7 SPOUSES ARE ELIGIBLE INDIVIDUALS WITH 1
 8 ACCOUNT.—If—

9 “(i) an individual and the individual’s
 10 spouse have both attained age 55 before
 11 the close of the taxable year, and

12 “(ii) the spouse is not an account ben-
 13 eficiary of a health savings account as of
 14 the close of such year,

15 the additional contribution amount shall be
 16 twice the amount otherwise determined under
 17 subparagraph (B).”.

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

21 **SEC. 117. PROVISIONS RELATING TO MEDICARE.**

22 (a) INDIVIDUALS OVER AGE 65 ONLY ENROLLED IN
 23 MEDICARE PART A.—Section 223(b)(7) of the Internal
 24 Revenue Code of 1986 is amended by adding at the end
 25 the following: “This paragraph shall not apply to any indi-
 26 vidual during any period for which the individual’s only

1 entitlement to such benefits is an entitlement to hospital
 2 insurance benefits under part A of title XVIII of such Act
 3 pursuant to an enrollment for such hospital insurance ben-
 4 efits under section 226(a)(1) of such Act.”.

5 (b) **MEDICARE BENEFICIARIES PARTICIPATING IN**
 6 **MEDICARE ADVANTAGE MSA MAY CONTRIBUTE THEIR**
 7 **OWN MONEY TO THEIR MSA.—**

8 (1) **IN GENERAL.—**Section 138(b) of such Code
 9 is amended by striking paragraph (2) and by redес-
 10 ignating paragraphs (3) and (4) as paragraphs (2)
 11 and (3), respectively.

12 (2) **CONFORMING AMENDMENT.—**Section
 13 138(c)(4) of such Code is amended by striking “and
 14 paragraph (2)”.

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

18 **SEC. 118. INDIVIDUALS ELIGIBLE FOR VETERANS BENE-**
 19 **FITS FOR A SERVICE-CONNECTED DIS-**
 20 **ABILITY.**

21 (a) **IN GENERAL.—**Section 223(c)(1) of the Internal
 22 Revenue Code of 1986 is amended by adding at the end
 23 the following new subparagraph:

24 “(C) **SPECIAL RULE FOR INDIVIDUALS ELI-**
 25 **GIBLE FOR CERTAIN VETERANS BENEFITS.—**

1 For purposes of subparagraph (A)(ii), an indi-
2 vidual shall not be treated as covered under a
3 health plan described in such subparagraph
4 merely because the individual receives periodic
5 hospital care or medical services for a service-
6 connected disability under any law administered
7 by the Secretary of Veterans Affairs but only if
8 the individual is not eligible to receive such care
9 or services for any condition other than a serv-
10 ice-connected disability.”.

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

14 **SEC. 119. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH**
15 **SERVICE ASSISTANCE.**

16 (a) IN GENERAL.—Section 223(c)(1) of the Internal
17 Revenue Code of 1986, as amended by the preceding pro-
18 visions of this Act, is amended by adding at the end the
19 following new subparagraph:

20 “(D) SPECIAL RULE FOR INDIVIDUALS EL-
21 IGIBLE FOR ASSISTANCE UNDER INDIAN
22 HEALTH SERVICE PROGRAMS.—For purposes of
23 subparagraph (A)(ii), an individual shall not be
24 treated as covered under a health plan de-
25 scribed in such subparagraph merely because

1 the individual receives hospital care or medical
2 services under a medical care program of the
3 Indian Health Service or of a tribal organiza-
4 tion.”.

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

8 **SEC. 120. INDIVIDUALS ELIGIBLE FOR TRICARE COVERAGE.**

9 (a) IN GENERAL.—Section 223(c)(1) of the Internal
10 Revenue Code of 1986, as amended by the preceding pro-
11 visions of this Act, is amended by adding at the end the
12 following new subparagraph:

13 “(E) SPECIAL RULE FOR INDIVIDUALS EL-
14 IGIBLE FOR ASSISTANCE UNDER TRICARE.—For
15 purposes of subparagraph (A)(ii), an individual
16 shall not be treated as covered under a health
17 plan described in such subparagraph merely be-
18 cause the individual is eligible to receive hos-
19 pital care, medical services, or prescription
20 drugs under TRICARE Extra or TRICARE
21 Standard and such individual is not enrolled in
22 TRICARE Prime.”.

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

1 **SEC. 121. FSA AND HRA INTERACTION WITH HSAS.**

2 (a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA
3 PARTICIPANTS.—Section 223(c)(1)(B) of the Internal
4 Revenue Code of 1986 is amended—

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

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

7 (iii) and inserting “, and”, and

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

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

21 “(I) coverage that does not pay
22 or reimburse any medical expense in-
23 curred before the minimum annual de-
24 ductible under paragraph (2)(A)(i)
25 (prorated for the period occurring

1 after the qualified HSA distribution is
2 made) is satisfied,

3 “(II) coverage that, after the
4 qualified HSA distribution is made,
5 does not pay or reimburse any med-
6 ical expense incurred after the quali-
7 fied HSA distribution is made other
8 than preventive care as defined in
9 paragraph (2)(C),

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

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

22 “(V) coverage that, after the
23 qualified HSA distribution is made,
24 pays or reimburses only those medical
25 expenses incurred after an individual’s

1 retirement (and no expenses incurred
2 before retirement), or

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

15 (b) QUALIFIED HSA DISTRIBUTION SHALL NOT AF-
16 FECT FLEXIBLE SPENDING ARRANGEMENT.—Section
17 106(e)(1) of such Code is amended to read as follows:

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

1 (c) FSA BALANCES AT YEAR END SHALL NOT FOR-
2 FEIT.—Section 125(d)(2) of such Code is amended by
3 adding at the end the following new subparagraph:

4 “(E) EXCEPTION FOR QUALIFIED HSA DIS-
5 TRIBUTIONS.—Subparagraph (A) shall not
6 apply to the extent that there is an amount re-
7 maining in a health flexible spending account at
8 the end of a plan year that an individual elects
9 to contribute to a health savings account pursu-
10 ant to a qualified HSA distribution (as defined
11 in section 106(e)(2)).”.

12 (d) SIMPLIFICATION OF LIMITATIONS ON FSA AND
13 HRA ROLLOVERS.—Section 106(e)(2) of such Code is
14 amended to read as follows:

15 “(2) QUALIFIED HSA DISTRIBUTION.—

16 “(A) IN GENERAL.—The term ‘qualified
17 HSA distribution’ means a distribution from a
18 health flexible spending arrangement or health
19 reimbursement arrangement to the extent that
20 such distribution does not exceed the lesser
21 of—

22 “(i) the balance in such arrangement
23 as of the date of such distribution, or

24 “(ii) the amount determined under
25 subparagraph (B).

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

3 “(B) DOLLAR LIMITATIONS.—

4 “(i) DISTRIBUTIONS FROM A HEALTH
5 FLEXIBLE SPENDING ARRANGEMENT.—A
6 qualified HSA distribution from a health
7 flexible spending arrangement shall not ex-
8 ceed the applicable amount.

9 “(ii) DISTRIBUTIONS FROM A HEALTH
10 REIMBURSEMENT ARRANGEMENT.—A
11 qualified HSA distribution from a health
12 reimbursement arrangement shall not ex-
13 ceed—

14 “(I) the applicable amount di-
15 vided by 12, multiplied by

16 “(II) the number of months dur-
17 ing which the individual is a partici-
18 pant in the health reimbursement ar-
19 rangement.

20 “(iii) APPLICABLE AMOUNT.—For
21 purposes of this subparagraph, the applica-
22 ble amount is—

23 “(I) the dollar amount in effect
24 under section 223(b)(2)(A) in the case
25 of an eligible individual who has self-

1 only coverage under a high deductible
2 health plan at the time of such dis-
3 tribution, and

4 “**(II)** twice the dollar amount in
5 effect under subclause **(I)** in the case
6 of an eligible individual who has fam-
7 ily coverage under a high deductible
8 health plan at the time of such dis-
9 tribution.”.

10 **(e) ELIMINATION OF ADDITIONAL TAX FOR FAILURE**
11 **TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COV-**
12 **ERAGE.**—Section 106(e) of such Code is amended—

13 (1) by striking paragraph (3) and redesignating
14 paragraphs (4) and (5) as paragraphs (3) and (4),
15 respectively, and

16 (2) by striking subparagraph **(A)** of paragraph
17 **(3)**, as so redesignated, and redesignating subpara-
18 graphs **(B)** and **(C)** of such paragraph as subpara-
19 graphs **(A)** and **(B)** thereof, respectively.

20 **(f) LIMITED PURPOSE FSAS AND HRAS.**—Section
21 106(e) of such Code, as amended by this section, is
22 amended by adding at the end the following new para-
23 graph:

24 “**(5) LIMITED PURPOSE FSAS AND HRAS.**—A
25 plan shall not fail to be a health flexible spending

1 arrangement or health reimbursement arrangement
2 under this section or section 105 merely because the
3 plan converts coverage for individuals who enroll in
4 a high deductible health plan described in section
5 223(c)(2) to coverage described in section
6 223(c)(1)(B)(iv). Coverage for such individuals may
7 be converted as of the date of enrollment in the high
8 deductible health plan, without regard to the period
9 of coverage under the health flexible spending ar-
10 rangement or health reimbursement arrangement,
11 and without requiring any change in coverage to in-
12 dividuals who do not enroll in a high deductible
13 health plan.”.

14 (g) DISCLAIMER OF DISQUALIFYING COVERAGE.—
15 Section 223(c)(1)(B) of such Code, as amended by this
16 section, is amended—

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

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

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

22 “(v) any coverage (including prospec-
23 tive coverage) under a health plan that is
24 not a high deductible health plan which is
25 disclaimed in writing, at the time of the

1 creation or organization of the health sav-
 2 ings account, including by execution of a
 3 trust described in subsection (d)(1)
 4 through a governing instrument that in-
 5 cludes such a disclaimer, or by acceptance
 6 of an amendment to such a trust that in-
 7 cludes such a disclaimer.”.

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

11 **SEC. 122. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**
 12 **INCURRED BEFORE ESTABLISHMENT OF AC-**
 13 **COUNT.**

14 (a) IN GENERAL.—Section 223(d)(2) of the Internal
 15 Revenue Code of 1986 is amended by adding at the end
 16 the following new subparagraph:

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

24 “(i) during either—

1 “(I) the taxable year in which the
2 health savings account was estab-
3 lished, or

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

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

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

21 **SEC. 123. PREVENTIVE CARE PRESCRIPTION DRUG CLARI-**
22 **FICATION.**

23 (a) CLARIFY USE OF DRUGS IN PREVENTIVE
24 CARE.—Section 223(c)(2)(C) of the Internal Revenue
25 Code of 1986 is amended by adding at the end the fol-

1 lowing: “Preventive care shall include prescription and
2 over-the-counter drugs and medicines which have the pri-
3 mary purpose of preventing the onset of, further deteriora-
4 tion from, or complications associated with chronic condi-
5 tions, illnesses, or diseases.”.

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

9 **SEC. 124. ADMINISTRATIVE ERROR CORRECTION BEFORE**
10 **DUE DATE OF RETURN.**

11 (a) IN GENERAL.—Section 223(f)(4) of the Internal
12 Revenue Code of 1986 is amended by adding at the end
13 the following new subparagraph:

14 “(D) EXCEPTION FOR ADMINISTRATIVE
15 ERRORS CORRECTED BEFORE DUE DATE OF RE-
16 TURN.—Subparagraph (A) shall not apply if
17 any payment or distribution is made to correct
18 an administrative, clerical or payroll contribu-
19 tion error and if—

20 “(i) such distribution is received by
21 the individual on or before the last day
22 prescribed by law (including extensions of
23 time) for filing such individual’s return for
24 such taxable year, and

1 “(ii) such distribution is accompanied
2 by the amount of net income attributable
3 to such contribution.

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

7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall take effect on the date of the enactment
9 of this Act.

10 **SEC. 125. MEMBERS OF HEALTH CARE SHARING MIN-**
11 **ISTRIES ELIGIBLE TO ESTABLISH HEALTH**
12 **SAVINGS ACCOUNTS.**

13 (a) IN GENERAL.—Section 223 of the Internal Rev-
14 enue Code of 1986, as amended by the preceding provi-
15 sions of this Act, is amended by adding at the end the
16 following new subsection:

17 “(j) APPLICATION TO HEALTH CARE SHARING MIN-
18 ISTRIES.—For purposes of this section, membership in a
19 health care sharing ministry (as defined in section
20 5000A(d)(2)(B)(ii)) shall be treated as coverage under a
21 high deductible health plan.”.

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. 126. HIGH DEDUCTIBLE HEALTH PLANS RENAMED**
2 **HSA QUALIFIED PLANS.**

3 (a) IN GENERAL.—Section 223 of the Internal Rev-
4 enue Code of 1986, as amended by this Act, is amended
5 by striking “high deductible health plan” each place it ap-
6 pears and inserting “HSA qualified health plan”.

7 (b) CONFORMING AMENDMENTS.—

8 (1) Section 106(e) of such Code, as amended by
9 this Act, is amended by striking “high deductible
10 health plan” each place it appears and inserting
11 “HSA qualified health plan”.

12 (2) The heading for section 223(c)(2) of such
13 Code is amended by striking “HIGH DEDUCTIBLE
14 HEALTH PLAN” and inserting “HSA QUALIFIED
15 HEALTH PLAN”.

16 (3) Section 408(d)(9) of such Code is amend-
17 ed—

18 (A) by striking “high deductible health
19 plan” each place it appears in subparagraph
20 (C) and inserting “HSA qualified health plan”,
21 and

22 (B) by striking “HIGH DEDUCTIBLE
23 HEALTH PLAN” in the heading of subparagraph
24 (D) and inserting “HSA QUALIFIED HEALTH
25 PLAN”.

1 **SEC. 127. TREATMENT OF DIRECT PRIMARY CARE SERVICE**
2 **ARRANGEMENTS.**

3 (a) IN GENERAL.—Section 223(c) of the Internal
4 Revenue Code of 1986 is amended by adding at the end
5 the following new paragraph:

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

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

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

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

18 **SEC. 128. CERTAIN PROVIDER FEES TO BE TREATED AS**
19 **MEDICAL CARE.**

20 (a) IN GENERAL.—Section 213(d) of the Internal
21 Revenue Code of 1986 is amended by adding at the end
22 the following new paragraph:

23 “(12) PERIODIC PROVIDER FEES.—The term
24 ‘medical care’ shall include periodic fees paid to a
25 primary care physician for the right to receive med-
26 ical services on an as-needed basis.”.

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. 129. CLARIFICATION OF TREATMENT OF CAPITATED**
 5 **PRIMARY CARE PAYMENTS AS AMOUNTS**
 6 **PAID FOR MEDICAL CARE.**

7 (a) IN GENERAL.—Section 213(d) of the Internal
 8 Revenue Code of 1986, as amended by the preceding pro-
 9 vision of this Act, is amended by adding at the end the
 10 following new paragraph:

11 “(13) TREATMENT OF CAPITATED PRIMARY
 12 CARE PAYMENTS.—Capitated primary care payments
 13 shall be treated as amounts paid for medical care.”.

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

17 **Subtitle C—Other Provisions**

18 **SEC. 131. LIMITATION ON EMPLOYER-PROVIDED HEALTH**
 19 **CARE COVERAGE.**

20 (a) IN GENERAL.—Section 106 of the Internal Rev-
 21 enue Code of 1986, as amended by the preceding provi-
 22 sions of this Act, is amended by adding at the end the
 23 following new subsection:

24 “(f) LIMITATION ON EMPLOYER-PROVIDED HEALTH
 25 CARE COVERAGE.—

1 “(1) IN GENERAL.—The amount of any exclu-
2 sion under subsection (a) for any taxable year with
3 respect to—

4 “(A) any employer-provided coverage
5 under an accident or health plan which con-
6 stitutes medical care, and

7 “(B) any employer contribution to an Ar-
8 cher MSA or a health savings account which is
9 treated by subsection (b) or (d) as employer-
10 provided coverage for medical expenses under
11 an accident or health plan,
12 shall not exceed \$8,000 per employee for self-only
13 coverage and \$20,000 for family coverage.

14 “(2) INFLATION ADJUSTMENT.—In the case of
15 any taxable year beginning in a calendar year after
16 2016, each dollar amount contained in paragraph
17 (1) shall be increased by an amount equal to—

18 “(A) such dollar amount, multiplied by

19 “(B) the cost-of-living adjustment deter-
20 mined under section 1(f)(3) for the calendar
21 year in which the taxable year begins, deter-
22 mined by substituting ‘calendar year 2015’ for
23 ‘calendar year 1992’ in subparagraph (B)
24 thereof.

1 Any increase determined under the preceding sen-
2 tence shall be rounded to the nearest multiple of
3 \$50.

4 “(3) MEDICAL CARE DEFINED.—For purposes
5 of paragraph (1), the term ‘medical care’ has the
6 meaning given to such term in section 213(d) deter-
7 mined without regard to—

8 “(A) paragraph (1)(C) thereof, and

9 “(B) so much of paragraph (1)(D) thereof
10 as relates to qualified long-term care insur-
11 ance.”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 this section shall apply to taxable years beginning after
14 December 31, 2015.

15 **SEC. 132. LIMITATION ON ABORTION FUNDING.**

16 No funds authorized under, or credits or deductions
17 allowed under the Internal Revenue Code of 1986 by rea-
18 son of, this Act (or any amendment made by this Act)
19 may be used to pay for any abortion or to cover any part
20 of the costs of any health plan that includes coverage of
21 abortion, except in the case where a woman suffers from
22 a physical disorder, physical injury, or physical illness that
23 would, as certified by a physician, place the woman in dan-
24 ger of death unless an abortion is performed, including
25 a life-endangering physical condition caused by or arising

1 from the pregnancy itself, or unless the pregnancy is the
2 result of an act of rape or incest.

3 **SEC. 133. NO GOVERNMENT DISCRIMINATION AGAINST**
4 **CERTAIN HEALTH CARE ENTITIES.**

5 (a) NON-DISCRIMINATION.—A Federal agency or
6 program, and any State or local government that receives
7 Federal financial assistance under this Act or any amend-
8 ment made by this Act (either directly or indirectly), may
9 not subject any individual or institutional health care enti-
10 ty to discrimination on the basis that the health care enti-
11 ty does not provide, pay for, provide coverage of, or refer
12 for abortions.

13 (b) HEALTH CARE ENTITY DEFINED.—For purposes
14 of this section, the term “health care entity” includes an
15 individual physician or other health care professional, a
16 hospital, a provider-sponsored organization, a health
17 maintenance organization, a health insurance plan, or any
18 other kind of health care facility, organization, or plan.

19 (c) REMEDIES.—

20 (1) IN GENERAL.—The courts of the United
21 States shall have jurisdiction to prevent and redress
22 actual or threatened violations of this section by
23 issuing any form of legal or equitable relief, includ-
24 ing—

1 (A) injunctions prohibiting conduct that
2 violates this section; and

3 (B) orders preventing the disbursement of
4 all or a portion of Federal financial assistance
5 to a State or local government, or to a specific
6 offending agency or program of a State or local
7 government, until such time as the conduct pro-
8 hibited by this section has ceased.

9 (2) COMMENCEMENT OF ACTION.—An action
10 under this subsection may be instituted by—

11 (A) any health care entity that has stand-
12 ing to complain of an actual or threatened vio-
13 lation of this section; or

14 (B) the Attorney General of the United
15 States.

16 (d) ADMINISTRATION.—The Secretary of Health and
17 Human Services shall designate the Director of the Office
18 for Civil Rights of the Department of Health and Human
19 Services—

20 (1) to receive complaints alleging a violation of
21 this section;

22 (2) subject to paragraph (3), to pursue the in-
23 vestigation of such complaints in coordination with
24 the Attorney General; and

1 (3) in the case of a complaint related to a Fed-
2 eral agency (other than with respect to the Depart-
3 ment of Health and Human Services) or program
4 administered through such other agency or any
5 State or local government receiving Federal financial
6 assistance through such other agency, to refer the
7 complaint to the appropriate office of such other
8 agency.

9 **SEC. 134. EQUAL EMPLOYER CONTRIBUTION RULE TO PRO-**
10 **MOTE CHOICE.**

11 (a) IN GENERAL.—Section 5000 of the Internal Rev-
12 enue Code of 1986 is amended by adding at the end the
13 following new subsection:

14 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

15 “(1) IN GENERAL.—Subsection (a) shall not
16 apply in the case of a group health plan with respect
17 to which the requirements of paragraphs (2) and (3)
18 are met.

19 “(2) CONTRIBUTION ELECTION.—The require-
20 ment of this paragraph is met with respect to a
21 group health plan if any employee of an employer
22 (who but for this paragraph would be covered by
23 such plan) may elect to have the employer or em-
24 ployee organization pay an amount which is not less
25 than the contribution amount to any provider of

1 health insurance coverage (other than excepted bene-
2 fits as defined in section 9832(c)) which constitutes
3 medical care of the individual or individual's spouse
4 or dependents in lieu of such group health plan cov-
5 erage otherwise provided or contributed to by the
6 employer with respect to such employee.

7 “(3) PRE-EXISTING CONDITIONS.—

8 “(A) IN GENERAL.—The requirement of
9 this paragraph is met with respect to health in-
10 surance coverage provided to a participant or
11 beneficiary by any health insurance issuer if,
12 under such plan the requirements of section
13 9801 are met with respect to the participant or
14 beneficiary.

15 “(B) ENFORCEMENT WITH RESPECT TO
16 INDIVIDUAL ELECTION.—For purposes of sub-
17 paragraph (A), any health insurance coverage
18 with respect to the participant or beneficiary
19 shall be treated as health insurance coverage
20 under a group health plan to which section
21 9801 applies.

22 “(4) CONTRIBUTION AMOUNT.—For purposes
23 of this section, the term ‘contribution amount’
24 means, with respect to an individual under a group
25 health plan, the portion of the applicable premium of

1 such individual under such plan (as determined
2 under section 4980B(f)(4)) which is not paid by the
3 individual. In the case that the employer offers more
4 than one group health plan, the contribution amount
5 shall be the average amount of the applicable pre-
6 miums under such plans.

7 “(5) GROUP HEALTH PLAN.—For purpose of
8 this subsection, subsection (d) shall not apply.

9 “(6) APPLICATION TO FEHBP.—Notwith-
10 standing any other provision of law, the Office of
11 Personnel Management shall carry out the health
12 benefits program under chapter 89 of title 5, United
13 States Code, consistent with the requirements of this
14 subsection.”.

15 (b) REQUIREMENT OF EQUAL CONTRIBUTIONS TO
16 ALL FEHBP PLANS.—Section 8906 of title 5, United
17 States Code, is amended by adding at the end the fol-
18 lowing new subsection:

19 “(j) Notwithstanding the previous provisions of this
20 section the Office of Personnel Management shall revise
21 the amount of the Government contribution made under
22 this section in a manner so that—

23 “(1) the amount of such contribution does not
24 change based on the health benefits plan in which
25 the individual is enrolled; and

1 “(2) the aggregate amount of such contribu-
2 tions is estimated to be equal to the aggregate
3 amount of such contributions if this subsection did
4 not apply.”.

5 (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT
6 OF 1974 CONFORMING AMENDMENTS.—

7 (1) EXCEPTION FROM HIPAA REQUIREMENTS
8 FOR BENEFITS PROVIDED UNDER HEALTH CARE
9 CONTRIBUTION ELECTION.—Section 732 of the Em-
10 ployee Retirement Income Security Act of 1974 (29
11 U.S.C. 1191a) is amended by adding at the end the
12 following new subsection:

13 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

14 “(1) IN GENERAL.—The requirements of this
15 part shall not apply in the case of health insurance
16 coverage (other than excepted benefits as defined in
17 section 9832(e) of the Internal Revenue Code of
18 1986)—

19 “(A) which is provided to a participant or
20 beneficiary by a health insurance issuer under
21 a group health plan, and

22 “(B) with respect to which the require-
23 ments of paragraphs (2) and (3) are met.

24 “(2) CONTRIBUTION ELECTION.—The require-
25 ment of this paragraph is met with respect to health

1 insurance coverage provided to a participant or ben-
2 eficiary by any health insurance issuer under a
3 group health plan if, under such plan—

4 “(A) the participant may elect such cov-
5 erage for any period of coverage in lieu of
6 health insurance coverage otherwise provided
7 under such plan for such period, and

8 “(B) in the case of such an election, the
9 plan sponsor is required to pay to such issuer
10 for the elected coverage for such period an
11 amount which is not less than the contribution
12 amount for such health insurance coverage oth-
13 erwise provided under such plan for such pe-
14 riod.

15 “(3) PRE-EXISTING CONDITIONS.—

16 “(A) IN GENERAL.—The requirement of
17 this paragraph is met with respect to health in-
18 surance coverage provided to a participant or
19 beneficiary by any health insurance issuer if,
20 under such plan the requirements of section
21 701 are met with respect to the participant or
22 beneficiary.

23 “(B) ENFORCEMENT WITH RESPECT TO
24 INDIVIDUAL ELECTION.—For purposes of sub-
25 paragraph (A), any health insurance coverage

1 with respect to the participant or beneficiary
2 shall be treated as health insurance coverage
3 under a group health plan to which section 701
4 applies.

5 “(4) CONTRIBUTION AMOUNT.—

6 “(A) IN GENERAL.—For purposes of this
7 section, the term ‘contribution amount’ means,
8 with respect to any period of health insurance
9 coverage offered to a participant or beneficiary,
10 the portion of the applicable premium of such
11 participant or beneficiary under such plan
12 which is not paid by such participant or bene-
13 ficiary. In the case that the employer offers
14 more than one group health plan, the contribu-
15 tion amount shall be the average amount of the
16 applicable premiums under such plans.

17 “(B) APPLICABLE PREMIUM.—For pur-
18 poses of subparagraph (A), the term ‘applicable
19 premium’ means, with respect to any period of
20 health insurance coverage of a participant or
21 beneficiary under a group health plan, the cost
22 to the plan for such period of such coverage for
23 similarly situated beneficiaries (without regard
24 to whether such cost is paid by the plan spon-
25 sor or the participant or beneficiary).”.

1 (2) EXEMPTION FROM FIDUCIARY LIABILITY.—
2 Section 404 of such Act (29 U.S.C. 1104) is amend-
3 ed by adding at the end the following new sub-
4 section:

5 “(e) The plan sponsor of a group health plan (as de-
6 fined in section 733(a)) shall not be treated as breaching
7 any of the responsibilities, obligations, or duties imposed
8 upon fiduciaries by this title in the case of any individual
9 who is a participant or beneficiary under such plan solely
10 because of the extent to which the plan sponsor provides,
11 in the case of such individual, some or all of such benefits
12 by means of payment of contribution amounts pursuant
13 to a contribution election under section 732(e), irrespec-
14 tive of the amount or type of benefits that would otherwise
15 be provided to such individual under such plan.”.

16 (d) EXCEPTION FROM HIPAA REQUIREMENTS
17 UNDER IRC FOR BENEFITS PROVIDED UNDER HEALTH
18 CARE CONTRIBUTION ELECTION.—Section 9831 of the
19 Internal Revenue Code of 1986 (relating to general excep-
20 tions) is amended by adding at the end the following new
21 subsection:

22 “(d) HEALTH CARE CONTRIBUTION ELECTION.—

23 “(1) IN GENERAL.—The requirements of this
24 chapter shall not apply in the case of health insur-

1 ance coverage (other than excepted benefits as de-
2 fined in section 9832(c))—

3 “(A) which is provided to a participant or
4 beneficiary by a health insurance issuer under
5 a group health plan, and

6 “(B) with respect to which the require-
7 ments of paragraphs (2) and (3) are met.

8 “(2) CONTRIBUTION ELECTION.—The require-
9 ment of this paragraph is met with respect to health
10 insurance coverage provided to a participant or ben-
11 eficiary by any health insurance issuer under a
12 group health plan if, under such plan—

13 “(A) the participant may elect such cov-
14 erage for any period of coverage in lieu of
15 health insurance coverage otherwise provided
16 under such plan for such period, and

17 “(B) in the case of such an election, the
18 plan sponsor is required to pay to such issuer
19 for the elected coverage for such period an
20 amount which is not less than the contribution
21 amount for such health insurance coverage oth-
22 erwise provided under such plan for such pe-
23 riod.

24 “(3) PRE-EXISTING CONDITIONS.—

1 “(A) IN GENERAL.—The requirement of
2 this paragraph is met with respect to health in-
3 surance coverage provided to a participant or
4 beneficiary by any health insurance issuer if,
5 under such plan the requirements of section
6 9801 are met with respect to the participant or
7 beneficiary.

8 “(B) ENFORCEMENT WITH RESPECT TO
9 INDIVIDUAL ELECTION.—For purposes of sub-
10 paragraph (A), any health insurance coverage
11 with respect to the participant or beneficiary
12 shall be treated as health insurance coverage
13 under a group health plan to which section
14 9801 applies.

15 “(4) CONTRIBUTION AMOUNT.—

16 “(A) IN GENERAL.—For purposes of this
17 subsection, the term ‘contribution amount’
18 means, with respect to any period of health in-
19 surance coverage offered to a participant or
20 beneficiary, the portion of the applicable pre-
21 mium of such participant or beneficiary under
22 such plan which is not paid by such participant
23 or beneficiary. In the case that the employer of-
24 fers more than one group health plan, the con-

1 tribution amount shall be the average amount
2 of the applicable premiums under such plans.

3 “(B) APPLICABLE PREMIUM.—For pur-
4 poses of subparagraph (A), the term ‘applicable
5 premium’ means, with respect to any period of
6 health insurance coverage of a participant or
7 beneficiary under a group health plan, the cost
8 to the plan for such period of such coverage for
9 similarly situated beneficiaries (without regard
10 to whether such cost is paid by the plan spon-
11 sor or the participant or beneficiary).”.

12 (e) EXCEPTION FROM HIPAA REQUIREMENTS
13 UNDER THE PHSA FOR BENEFITS PROVIDED UNDER
14 HEALTH CARE CONTRIBUTION ELECTION.—Section 2721
15 of the Public Health Service Act (42 U.S.C. 300gg–21)
16 is amended—

17 (1) by redesignating subsection (e) as sub-
18 section (f); and

19 (2) by inserting after subsection (d) the fol-
20 lowing new subsection:

21 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

22 “(1) IN GENERAL.—The requirements of sub-
23 parts 1 through 3 shall not apply in the case of
24 health insurance coverage (other than excepted bene-

1 fits as defined in section 9832(c) of the Internal
2 Revenue Code of 1986)—

3 “(A) which is provided to a participant or
4 beneficiary by a health insurance issuer under
5 a group health plan, and

6 “(B) with respect to which the require-
7 ments of paragraphs (2) and (3) are met.

8 “(2) CONTRIBUTION ELECTION.—The require-
9 ment of this paragraph is met with respect to health
10 insurance coverage provided to a participant or ben-
11 efiiciary by any health insurance issuer under a
12 group health plan if, under such plan—

13 “(A) the participant may elect such cov-
14 erage for any period of coverage in lieu of
15 health insurance coverage otherwise provided
16 under such plan for such period, and

17 “(B) in the case of such an election, the
18 plan sponsor is required to pay to such issuer
19 for the elected coverage for such period an
20 amount which is not less than the contribution
21 amount for such health insurance coverage oth-
22 erwise provided under such plan for such pe-
23 riod.

24 “(3) PRE-EXISTING CONDITIONS.—

1 “(A) IN GENERAL.—The requirement of
2 this paragraph is met with respect to health in-
3 surance coverage provided to a participant or
4 beneficiary by any health insurance issuer if,
5 under such plan the requirements of section
6 2701 are met with respect to the participant or
7 beneficiary.

8 “(B) ENFORCEMENT WITH RESPECT TO
9 INDIVIDUAL ELECTION.—For purposes of sub-
10 paragraph (A), any health insurance coverage
11 with respect to the participant or beneficiary
12 shall be treated as health insurance coverage
13 under a group health plan to which section
14 2701 applies.

15 “(4) CONTRIBUTION AMOUNT.—

16 “(A) IN GENERAL.—For purposes of this
17 section, the term ‘contribution amount’ means,
18 with respect to any period of health insurance
19 coverage offered to a participant or beneficiary,
20 the portion of the applicable premium of such
21 participant or beneficiary under such plan
22 which is not paid by such participant or bene-
23 ficiary. In the case that the employer offers
24 more than one group health plan, the contribu-

1 tion amount shall be the average amount of the
2 applicable premiums under such plans.

3 “(B) APPLICABLE PREMIUM.—For pur-
4 poses of subparagraph (A), the term ‘applicable
5 premium’ means, with respect to any period of
6 health insurance coverage of a participant or
7 beneficiary under a group health plan, the cost
8 to the plan for such period of such coverage for
9 similarly situated beneficiaries (without regard
10 to whether such cost is paid by the plan spon-
11 sor or the participant or beneficiary).”.

12 **SEC. 135. LIMITATIONS ON STATE RESTRICTIONS ON EM-**
13 **EMPLOYER AUTO-ENROLLMENT.**

14 (a) IN GENERAL.—No State shall establish a law
15 that prevents an employer that is allowed an exclusion
16 from gross income, a deduction, or a credit for Federal
17 income tax purposes for health benefits furnished to a par-
18 ticipant or beneficiary from instituting auto-enrollment
19 which meets the requirements of subsection (b) for cov-
20 erage of a participant or beneficiary under a group health
21 plan, or health insurance coverage offered in connection
22 with such a plan, so long as the participant or beneficiary
23 has the option of declining such coverage.

24 (b) AUTOMATIC ENROLLMENT FOR EMPLOYER-
25 SPONSORED HEALTH BENEFITS.—

1 (1) IN GENERAL.—The requirement of this sub-
2 section with respect to an employer and an employee
3 is that the employer automatically enroll such em-
4 ployee into the employment-based health benefits
5 plan for individual coverage under the plan option
6 with the lowest applicable employee premium.

7 (2) OPT-OUT.—In no case may an employer
8 automatically enroll an employee in a plan under
9 paragraph (1) if such employee makes an affirmative
10 election to opt-out of such plan or to elect coverage
11 under an employment-based health benefits plan of-
12 fered by such employer. An employer shall provide
13 an employee with a 30-day period to make such an
14 affirmative election before the employer may auto-
15 matically enroll the employee in such a plan.

16 (3) NOTICE REQUIREMENTS.—

17 (A) IN GENERAL.—Each employer de-
18 scribed in paragraph (1) who automatically en-
19 rolls an employee into a plan as described in
20 such paragraph shall provide the employees,
21 within a reasonable period before the beginning
22 of each plan year (or, in the case of new em-
23 ployees, within a reasonable period before the
24 end of the enrollment period for such a new em-
25 ployee), written notice of the employees' rights

1 and obligations relating to the automatic enroll-
2 ment requirement under such paragraph. Such
3 notice must be comprehensive and understood
4 by the average employee to whom the automatic
5 enrollment requirement applies.

6 (B) INCLUSION OF SPECIFIC INFORMA-
7 TION.—The written notice under subparagraph
8 (A) must explain an employee’s right to opt out
9 of being automatically enrolled in a plan and in
10 the case that more than one level of benefits or
11 employee premium level is offered by the em-
12 ployer involved, the notice must explain which
13 level of benefits and employee premium level the
14 employee will be automatically enrolled in the
15 absence of an affirmative election by the em-
16 ployee.

17 (c) CONSTRUCTION.—Nothing in this section shall be
18 construed to supersede State law which establishes, imple-
19 ments, or continues in effect any standard or requirement
20 relating to employers in connection with payroll or the
21 sponsoring of employer-sponsored health insurance cov-
22 erage except to the extent that such standard or require-
23 ment prevents an employer from instituting the auto-en-
24 rollment described in subsection (a).

1 (d) NON-APPLICATION TO EXCEPTED BENEFITS.—
 2 For purposes of this section, the term “group health plan”
 3 does not include excepted benefits (as defined in section
 4 2781(c) of the Public Health Service Act (42 U.S.C.
 5 300gg-91(e))).

6 **SEC. 136. CREDIT FOR SMALL EMPLOYERS ADOPTING**
 7 **AUTO-ENROLLMENT AND DEFINED CON-**
 8 **TRIBUTION OPTIONS.**

9 (a) IN GENERAL.—Subpart D of part IV of sub-
 10 chapter A of chapter 1 of the Internal Revenue Code of
 11 1986, as amended by section 2, is amended by adding at
 12 the end the following new section:

13 **“SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBU-**
 14 **TION OPTION FOR HEALTH BENEFITS PLANS**
 15 **OF SMALL EMPLOYERS.**

16 “(a) IN GENERAL.—For purposes of section 38, in
 17 the case of a small employer, the health benefits plan im-
 18 plementation credit determined under this section for the
 19 taxable year is an amount equal to 100 percent of the
 20 amount paid or incurred by the taxpayer during the tax-
 21 able year for qualified health benefits expenses.

22 “(b) LIMITATION.—The credit determined under sub-
 23 section (a) with respect to any taxpayer for any taxable
 24 year shall not exceed the excess of—

25 “(1) \$1,500, over

1 “(2) sum of the credits determined under sub-
2 section (a) with respect to such taxpayer for all pre-
3 ceding taxable years.

4 “(c) QUALIFIED HEALTH BENEFITS EXPENSES.—
5 For purposes of this section, the term ‘qualified health
6 benefits auto-enrollment expenses’ means, with respect to
7 any taxable year, amounts paid or incurred by the tax-
8 payer during such taxable year for—

9 “(1) establishing auto-enrollment which meets
10 the requirements of section 107 of the Empowering
11 Patients First Act of 2013 for coverage of a partici-
12 pant or beneficiary under a group health plan, or
13 health insurance coverage offered in connection with
14 such a plan, and

15 “(2) implementing the employer contribution
16 option for health insurance coverage pursuant to
17 section 5000(e)(2).

18 “(d) QUALIFIED SMALL EMPLOYER.—For purposes
19 of this section, the term ‘qualified small employer’ means
20 any employer for any taxable year if the number of em-
21 ployees employed by such employer during such taxable
22 year does not exceed 50. All employers treated as a single
23 employer under section (a) or (b) of section 52 shall be
24 treated as a single employer for purposes of this section.

1 “(e) NO DOUBLE BENEFIT.—No deduction or credit
2 shall be allowed under any other provision of this chapter
3 with respect to the amount of the credit determined under
4 this section.

5 “(f) TERMINATION.—Subsection (a) shall not apply
6 to any taxable year beginning after the date which is 2
7 years after the date of the enactment of this section.”.

8 (b) CREDIT TO BE PART OF GENERAL BUSINESS
9 CREDIT.—Subsection (b) of section 38 of such Code, as
10 amended by section 2, is amended by striking “plus” at
11 the end of paragraph (34), by striking the period at the
12 end of paragraph (35) and inserting “, plus”, and by add-
13 ing at the end the following new paragraph:

14 “(36) in the case of a small employer (as de-
15 fined in section 45R(d)), the health benefits plan im-
16 plementation credit determined under section
17 45R(a).”.

18 (c) CLERICAL AMENDMENT.—The table of sections
19 for subpart D of part IV of subchapter A of chapter 1
20 of such Code, as amended by section 2, is amended by
21 inserting after the item relating to section 45Q the fol-
22 lowing new item:

“Sec. 45R. Auto-enrollment and defined contribution option for health benefits
plans of small employers.”.

1 (d) 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 **TITLE II—HEALTH CARE ACCESS**
5 **AND AVAILABILITY**

6 **Subtitle A—Health Insurance Pool-**
7 **ing Mechanisms for Individuals**

8 **SEC. 201. FEDERAL GRANTS FOR STATE INSURANCE EX-**
9 **PENDITURES.**

10 (a) IN GENERAL.—Subject to the succeeding provi-
11 sions of this section, each State shall receive from the Sec-
12 retary of Health and Human Services (in this subtitle re-
13 ferred to as the “Secretary”) a grant for the State’s pro-
14 viding for the use, in connection with providing health ben-
15 efits coverage, of a qualifying high-risk pool or a reinsur-
16 ance pool or other risk-adjustment mechanism used for
17 the purpose of subsidizing the purchase of private health
18 insurance.

19 (b) FUNDING AMOUNT.—

20 (1) IN GENERAL.—There are hereby appro-
21 priated, out of any funds in the Treasury not other-
22 wise appropriated, \$1,000,000,000 for each of fiscal
23 years 2016, 2017, and 2018 for grants under this
24 section. Such amount shall be divided among the
25 States as determined by the Secretary.

1 (2) CONSTRUCTION.—Nothing in this section
2 shall be construed as preventing a State from using
3 funding under section 2745 of the Public Health
4 Service Act for purposes of funding reinsurance or
5 other risk mechanisms.

6 (c) LIMITATION.—Funding under subsection (a) may
7 only be used for the following:

8 (1) QUALIFYING HIGH-RISK POOLS.—

9 (A) CURRENT POOLS.—A qualifying high-
10 risk pool created before the date of the enact-
11 ment of this Act that only covers high-risk pop-
12 ulations and individuals (and their spouse and
13 dependents) receiving a health care tax credit
14 under section 35 of the Internal Revenue Code
15 of 1986 for a limited period of time as deter-
16 mined by the Secretary or under section 2741
17 of Public Health Service Act.

18 (B) NEW POOLS.—A qualifying high-risk
19 pool created on or after such date that only cov-
20 ers populations and individuals described in
21 subparagraph (A) if the pool—

22 (i) offers at least the option of one or
23 more high-deductible plan options, in com-
24 bination with a contribution into a health
25 savings account;

1 (ii) offers multiple competing health
2 plan options; and

3 (iii) covers only high-risk populations.

4 (2) RISK INSURANCE POOL OR OTHER RISK-AD-
5 JUSTMENT MECHANISMS.—

6 (A) CURRENT REINSURANCE.—A reinsur-
7 ance pool, or other risk-adjustment mechanism,
8 created before the date of the enactment of this
9 Act that only covers populations and individuals
10 described in paragraph (1)(A).

11 (B) NEW POOLS.—A reinsurance pool or
12 other risk-adjustment mechanism created on or
13 after such date that provides reinsurance only
14 covers populations and individuals described in
15 paragraph (1)(A) and only on a prospective
16 basis under which a health insurance issuer
17 cedes covered lives to the pool in exchange for
18 payment of a reinsurance premium.

19 (3) TRANSITION.—Nothing in this section shall
20 be construed as preventing a State from using funds
21 available to transition from an existing high-risk
22 pool to a reinsurance pool.

23 (d) BONUS PAYMENTS.—With respect to any
24 amounts made available to the States under this section,
25 the Secretary shall set aside a portion of such amounts

1 that shall only be available for the following activities by
2 such States:

3 (1) Providing guaranteed availability of indi-
4 vidual health insurance coverage to certain individ-
5 uals with prior group coverage under part B of title
6 XXVII of the Public Health Service Act.

7 (2) A reduction in premium trends, actual pre-
8 miums, or other cost-sharing requirements.

9 (3) An expansion or broadening of the pool of
10 high-risk individuals eligible for coverage.

11 (4) States that adopt the Model Health Plan
12 for Uninsurable Individuals Act of the National As-
13 sociation of Insurance Commissioners (if and when
14 updated by such Association).

15 The Secretary may request such Association to update
16 such Model Health Plan as needed by 2015.

17 (e) REQUIREMENTS FOR RECEIPT OF BONUS PAY-
18 MENTS.—The requirements of this subsection, for the
19 availability of bonus payments to a State under subsection
20 (d), are as follows, in the case of an individual who is cov-
21 ered under a high-risk pool or other pool or mechanism
22 described in subsection (b) operating in the State for
23 which funds under this section may be applied:

24 (1) LIMITATION ON ANNUAL PREMIUMS FOR
25 EACH INDIVIDUAL BASED ON ADJUSTED GROSS FAM-

1 ILY INCOME.—The premiums imposed for coverage
2 of each individual under health insurance coverage
3 offered through such pool or mechanism may not ex-
4 ceed (on an annual basis) the following:

5 (A) If the adjusted gross income (as de-
6 fined in section 62 of the Internal Revenue
7 Code of 1986) of all individuals in the individ-
8 ual’s family does not exceed the poverty line (as
9 defined in section 673(2) of the Community
10 Services Block Grant Act (42 U.S.C. 9902(2)),
11 including any revision required by such section)
12 applicable to a family of the size involved, 2
13 percent of such income.

14 (B) If such adjusted gross income for all
15 individuals in the individual’s family exceeds
16 such applicable poverty line, the sum of—

17 (i) 2 percent of such applicable pov-
18 erty line; and

19 (ii) 10 percent of the amount of such
20 income that exceeds such applicable pov-
21 erty line.

22 (2) LIMITATION ON ANNUAL OUT-OF-POCKET
23 COSTS FOR EACH INDIVIDUAL.—There shall be a
24 limit on the annual out-of-pocket expenditures (in-
25 cluding annual premiums) for each individual for

1 coverage under such pool or mechanism equal to
2 twice the maximum allowable premiums for such in-
3 dividual permitted under paragraph (1).

4 (f) ADMINISTRATION.—The Secretary shall provide
5 for the administration of this section and may establish
6 such terms and conditions, including the requirement of
7 an application, as may be appropriate to carry out this
8 section.

9 (g) CONSTRUCTION.—Nothing in this section shall be
10 construed as requiring a State to operate a reinsurance
11 pool (or other risk-adjustment mechanism) under this sec-
12 tion or as preventing a State from operating such a pool
13 or mechanism through one or more private entities.

14 (h) DEFINITIONS.—In this section:

15 (1) QUALIFYING HIGH-RISK POOL.—The term
16 “qualifying high-risk pool” means any qualified
17 high-risk pool (as defined in subsection (g)(1)(A) of
18 section 2745 of the Public Health Service Act) that
19 meets the conditions to receive a grant under section
20 (b)(1) of such section.

21 (2) REINSURANCE POOL OR OTHER RISK-AD-
22 JUSTMENT MECHANISM DEFINED.—The term “rein-
23 surance pool or other risk-adjustment mechanism”
24 means any State-based risk spreading mechanism to

1 subsidize the purchase of private health insurance
2 for the high-risk population.

3 (3) HIGH-RISK POPULATION.—The term “high-
4 risk population” means—

5 (A) individuals who, by reason of the exist-
6 ence or history of a medical condition, are able
7 to acquire health coverage only at rates which
8 are at least 150 percent of the standard risk
9 rates for such coverage (in a non-community-
10 rated non-guaranteed issue State), and

11 (B) individuals who are provided health
12 coverage by a high-risk pool.

13 (4) STATE DEFINED.—The term “State” in-
14 cludes the District of Columbia, Puerto Rico, the
15 Virgin Islands, Guam, American Samoa, and the
16 Northern Mariana Islands.

17 (i) EXTENDING FUNDING.—Section 2745(d)(2) of
18 the Public Health Service Act (42 U.S.C. 300gg–45(d)(2))
19 is amended—

20 (1) in the heading, by inserting “AND 2016
21 THROUGH 2018” after “2010”; and

22 (2) by inserting “and for each of fiscal years
23 2016 through 2018” after “for each of fiscal years
24 2007 through 2010”.

1 (j) SUNSET.—Funds made available under this sec-
 2 tion shall not be used for the purpose of subsidizing the
 3 purchase of private health insurance on or after October
 4 1, 2018.

5 **SEC. 202. POOL REFORM FOR INDIVIDUAL MEMBERSHIP**
 6 **EXPANSION.**

7 The Public Health Service Act, as amended by sec-
 8 tion 2, is further amended by inserting after title XXX
 9 the following new title:

10 **“TITLE XXXI—POOL REFORM**
 11 **FOR INDIVIDUAL MEMBER-**
 12 **SHIP EXPANSION**

13 **“SEC. 3100. PURPOSE.**

14 “The purpose of this title is to provide, through the
 15 establishment of independent health pools (or IHPs), for
 16 the reform of, and expansion of enrollment in, health in-
 17 surance coverage for individuals and small employers.

18 **“SEC. 3101. DEFINITION OF INDEPENDENT HEALTH POOL**
 19 **(IHP).**

20 “(a) IN GENERAL.—For purposes of this title, the
 21 terms ‘individual health pool’ and ‘IHP’ mean a legal non-
 22 profit entity that meets the following requirements:

23 “(1) ORGANIZATION.—The IHP—

24 “(A) has been formed and maintained in
 25 good faith for a purpose that includes the for-

1 mation of a risk pool in order to offer health in-
2 surance coverage to its members;

3 “(B) does not condition membership in the
4 IHP on any health status-related factor relating
5 to an individual (including an employee of an
6 employer or a dependent of an employee);

7 “(C) does not make health insurance cov-
8 erage offered through the IHP available other
9 than in connection with a member of the IHP;

10 “(D) is not a health insurance issuer; and

11 “(E) does not receive any consideration di-
12 rectly or indirectly from any health insurance
13 issuer in connection with the enrollment of any
14 individuals, or employees of employers, in any
15 health insurance coverage, except in conjunction
16 with services offered through the IHP.

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

19 “(A) DIFFERENT GROUPS.—The IHP, in
20 conjunction with those health insurance issuers
21 that offer health benefits coverage through the
22 IHP, makes available health benefits coverage
23 in the manner described in subsection (b) to all
24 members of the IHP and the dependents of
25 such members (and, in the case of small em-

1 ployers, employees and their dependents) in the
2 manner described in subsection (c)(2) at rates
3 that are established by the health insurance
4 issuer on a policy or product specific basis and
5 that may vary for individuals covered through
6 an IHP.

7 “(B) NONDISCRIMINATION IN COVERAGE
8 OFFERED.—

9 “(i) IN GENERAL.—Subject to clause
10 (ii), the IHP may not offer health benefits
11 coverage to a member of an IHP unless
12 the same coverage is offered to all such
13 members of the IHP.

14 “(ii) CONSTRUCTION.—Nothing in
15 this title shall be construed as requiring or
16 permitting a health insurance issuer to
17 provide coverage outside the service area of
18 the issuer, as approved under State law, or
19 preventing a health insurance issuer from
20 underwriting or from excluding or limiting
21 the coverage on any individual, subject to
22 the requirement of section 2741 (relating
23 to guaranteed availability of individual
24 health insurance coverage to certain indi-
25 viduals with prior group coverage).

1 “(C) NO ASSUMPTION OF INSURANCE RISK
2 BY IHP.—The IHP provides health benefits cov-
3 erage only through contracts with health insur-
4 ance issuers and does not assume insurance
5 risk with respect to such coverage.

6 “(3) GEOGRAPHIC AREAS.—Nothing in this title
7 shall be construed as preventing the establishment
8 and operation of more than one IHP in a geographic
9 area or as limiting the number of IHPs that may
10 operate in any area.

11 “(4) PROVISION OF ADMINISTRATIVE SERVICES
12 TO PURCHASERS.—The IHP may provide adminis-
13 trative services for members. Such services may in-
14 clude accounting, billing, and enrollment informa-
15 tion.

16 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
17 MENTS.—

18 “(1) COMPLIANCE WITH CONSUMER PROTEC-
19 TION REQUIREMENTS.—Except as provided in sec-
20 tion 3102, any health benefits coverage offered
21 through an IHP—

22 “(A) shall be issued by a health insurance
23 issuer that meets all applicable State standards
24 relating to consumer protection;

1 “(B) shall be approved or otherwise per-
2 mitted to be offered under State law; and

3 “(C) may not impose any exclusion of a
4 specific disease from such coverage.

5 “(2) WELLNESS BONUSES FOR HEALTH PRO-
6 MOTION.—Nothing in this title shall be construed as
7 precluding a health insurance issuer offering health
8 benefits coverage through an IHP from establishing
9 premium discounts or rebates for members or from
10 modifying otherwise applicable copayments or
11 deductibles in return for adherence to programs of
12 health promotion and disease prevention so long as
13 such programs are agreed to in advance by the IHP
14 and comply with all other provisions of this title and
15 do not discriminate among similarly situated mem-
16 bers.

17 “(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

18 “(1) MEMBERS.—

19 “(A) IN GENERAL.—Under rules estab-
20 lished to carry out this title, with respect to an
21 individual or small employer who is a member
22 of an IHP, the individual may enroll for health
23 benefits coverage (including coverage for de-
24 pendents of such individual) or employer may
25 enroll employees for health benefits coverage

1 (including coverage for dependents of such em-
2 ployees) offered by a health insurance issuer
3 through the IHP.

4 “(B) RULES FOR ENROLLMENT.—Nothing
5 in this paragraph shall preclude an IHP from
6 establishing rules of enrollment and reenroll-
7 ment of members. Such rules shall be applied
8 consistently to all members within the IHP and
9 shall not be based in any manner on health sta-
10 tus-related factors.

11 “(2) HEALTH INSURANCE ISSUERS.—The con-
12 tract between an IHP and a health insurance issuer
13 shall provide, with respect to a member enrolled with
14 health benefits coverage offered by the issuer
15 through the IHP, for the payment to the issuer of
16 the premiums (if any) collected by the IHP for
17 health insurance coverage offered by the issuer.

18 **“SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
19 **MENTS.**

20 “(a) PREEMPTION OF STATE LAWS RESTRICTING
21 FORMATION OF IHPs.—Any State law or regulation relat-
22 ing to the composition or organization of an IHP is pre-
23 empted to the extent the law or regulation is inconsistent
24 with the provisions of this title.

1 “(b) PREEMPTION OF STATE REQUIREMENTS RE-
2 LATING TO HEALTH BENEFIT COVERAGE.—

3 “(1) BENEFIT REQUIREMENTS.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), State laws are superseded, and shall
6 not apply to health benefits coverage made
7 available through an IHP, insofar as such laws
8 impose benefit requirements for such coverage,
9 including (but not limited to) requirements re-
10 lating to coverage of specific providers, specific
11 services or conditions, or the amount, duration,
12 or scope of benefits.

13 “(B) EXCEPTION FOR FEDERALLY IM-
14 POSED REQUIREMENTS AND FOR REQUIRE-
15 MENTS PROHIBITING DISEASE-SPECIFIC EXCLU-
16 SIONS.—Subparagraph (A) shall not apply to a
17 requirement to the extent the requirement—

18 “(i) implements title XXVII or other
19 Federal law; or

20 “(ii) prohibits imposition of an exclu-
21 sion of a specific disease from health bene-
22 fits coverage.

23 “(2) OTHER REQUIREMENTS PREVENTING OF-
24 FERING OF COVERAGE THROUGH AN IHP.—State
25 laws are superseded, and shall not apply to health

1 benefits coverage made available through an IHP,
2 insofar as such laws impose any other requirements
3 (including limitations on compensation arrange-
4 ments) that, directly or indirectly, preclude (or have
5 the effect of precluding) the offering of such cov-
6 erage through an IHP, if the IHP meets the re-
7 quirements of this title.

8 “(c) PREEMPTION OF STATE PREMIUM RATING RE-
9 QUIREMENTS.—State laws are superseded, and shall not
10 apply to the premiums imposed for health benefits cov-
11 erage made available through an IHP, insofar as such
12 laws impose restrictions on the variation of premiums
13 among such coverage offered to members of the IHP.

14 **“SEC. 3103. DEFINITIONS.**

15 “For purposes of this title:

16 “(1) DEPENDENT.—The term ‘dependent’, as
17 applied to health insurance coverage offered by a
18 health insurance issuer licensed (or otherwise regu-
19 lated) in a State, shall have the meaning applied to
20 such term with respect to such coverage under the
21 laws of the State relating to such coverage and such
22 an issuer. Such term may include the spouse and
23 children of the individual involved.

24 “(2) HEALTH BENEFITS COVERAGE.—The term
25 ‘health benefits coverage’ has the meaning given the

1 term health insurance coverage in section
2 2791(b)(1), and does not include excepted benefits
3 (as defined in section 2791(c)).

4 “(3) HEALTH INSURANCE ISSUER.—The term
5 ‘health insurance issuer’ has the meaning given such
6 term in section 2791(b)(2).

7 “(4) HEALTH STATUS-RELATED FACTOR.—The
8 term ‘health status-related factor’ has the meaning
9 given such term in section 2791(d)(9).

10 “(5) MEMBER.—The term ‘member’ means,
11 with respect to an IHP, an individual or small em-
12 ployer who is a member of the legal entity described
13 in section 3101(a)(1) to which the IHP is offering
14 coverage.

15 “(6) SMALL EMPLOYER.—The term ‘small em-
16 ployer’ has the meaning given such term in section
17 712(c)(1)(B) of the Employee Retirement and In-
18 come Security Act of 1974.”.

19 **Subtitle B—Small Business Health** 20 **Fairness**

21 **SEC. 211. SHORT TITLE.**

22 This subtitle may be cited as the “Small Business
23 Health Fairness Act of 2015”.

1 **SEC. 212. RULES GOVERNING ASSOCIATION HEALTH**
2 **PLANS.**

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

6 **“PART 8—RULES GOVERNING ASSOCIATION**
7 **HEALTH PLANS**

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

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

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

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

1 1986)), for substantial purposes other than that of
2 obtaining or providing medical care;

3 “(2) is established as a permanent entity which
4 receives the active support of its members and re-
5 quires for membership payment on a periodic basis
6 of dues or payments necessary to maintain eligibility
7 for membership in the sponsor; and

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

15 Any sponsor consisting of an association of entities which
16 meet the requirements of paragraphs (1), (2), and (3)
17 shall be deemed to be a sponsor described in this sub-
18 section.

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

21 “(a) IN GENERAL.—The applicable authority shall
22 prescribe by regulation a procedure under which, subject
23 to subsection (b), the applicable authority shall certify as-
24 sociation health plans which apply for certification as
25 meeting the requirements of this part.

1 “(b) STANDARDS.—Under the procedure prescribed
2 pursuant to subsection (a), in the case of an association
3 health plan that provides at least one benefit option which
4 does not consist of health insurance coverage, the applica-
5 ble authority shall certify such plan as meeting the re-
6 quirements of this part only if the applicable authority is
7 satisfied that the applicable requirements of this part are
8 met (or, upon the date on which the plan is to commence
9 operations, will be met) with respect to the plan.

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

16 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
17 CATION.—The applicable authority may provide by regula-
18 tion for continued certification of association health plans
19 under this part.

20 “(e) CLASS CERTIFICATION FOR FULLY INSURED
21 PLANS.—The applicable authority shall establish a class
22 certification procedure for association health plans under
23 which all benefits consist of health insurance coverage.
24 Under such procedure, the applicable authority shall pro-
25 vide for the granting of certification under this part to

1 the plans in each class of such association health plans
2 upon appropriate filing under such procedure in connec-
3 tion with plans in such class and payment of the pre-
4 scribed fee under section 807(a).

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

10 “(1) a plan which offered such coverage on the
11 date of the enactment of the Small Business Health
12 Fairness Act of 2015,

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

18 “(3) a plan whose eligible participating employ-
19 ers represent one or more trades or businesses, or
20 one or more industries, consisting of any of the fol-
21 lowing: agriculture; equipment and automobile deal-
22 erships; barbering and cosmetology; certified public
23 accounting practices; child care; construction; dance,
24 theatrical and orchestra productions; disinfecting
25 and pest control; financial services; fishing; food

1 service establishments; hospitals; labor organiza-
2 tions; logging; manufacturing (metals); mining; med-
3 ical and dental practices; medical laboratories; pro-
4 fessional consulting services; sanitary services; trans-
5 portation (local and freight); warehousing; whole-
6 saling/distributing; or any other trade or business or
7 industry which has been indicated as having average
8 or above-average risk or health claims experience by
9 reason of State rate filings, denials of coverage, pro-
10 posed premium rate levels, or other means dem-
11 onstrated by such plan in accordance with regula-
12 tions.

13 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
14 **BOARDS OF TRUSTEES.**

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

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

24 “(1) FISCAL CONTROL.—The plan is operated,
25 pursuant to a trust agreement, by a board of trust-

1 ees which has complete fiscal control over the plan
2 and which is responsible for all operations of the
3 plan.

4 “(2) RULES OF OPERATION AND FINANCIAL
5 CONTROLS.—The board of trustees has in effect
6 rules of operation and financial controls, based on a
7 3-year plan of operation, adequate to carry out the
8 terms of the plan and to meet all requirements of
9 this title applicable to the plan.

10 “(3) RULES GOVERNING RELATIONSHIP TO
11 PARTICIPATING EMPLOYERS AND TO CONTRAC-
12 TORS.—

13 “(A) BOARD MEMBERSHIP.—

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

22 “(ii) LIMITATION.—

23 “(I) GENERAL RULE.—Except as
24 provided in subclauses (II) and (III),
25 no such member is an owner, officer,

1 director, or employee of, or partner in,
2 a contract administrator or other
3 service provider to the plan.

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

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

24 “(iii) CERTAIN PLANS EXCLUDED.—
25 Clause (i) shall not apply to an association

1 health plan which is in existence on the
2 date of the enactment of the Small Busi-
3 ness Health Fairness Act of 2015.

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

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

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

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

23 The Secretary may by regulation define for purposes of
24 this subsection the terms ‘franchiser’, ‘franchise network’,
25 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 2015, 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
15 health actuary, 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 health actuary. The applicable

1 authority may by regulation provide for ad-
2 justments in the amount of such insurance
3 in specified circumstances in which the
4 plan specifically provides for and maintains
5 reserves 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 health actuary may
19 recommend, 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 DEMNFICATION 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 2015, 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 As-
16 sociation 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
24 the type referred to in section 801(b)(1), or
25 their interests.

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 health actuary, that all applicable re-
7 quirements of section 806 are or will be met in
8 accordance with regulations which the applica-
9 ble authority shall prescribe.

10 “(B) ADEQUACY OF CONTRIBUTION
11 RATES.—A statement of actuarial opinion,
12 signed by a qualified health actuary, which sets
13 forth a description of the extent to which con-
14 tribution rates are adequate to provide for the
15 payment of all obligations and the maintenance
16 of required 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 health ac-
2 tuary, which sets forth the current value of the
3 assets and liabilities accumulated under the
4 plan and a projection of the assets, liabilities,
5 income, and expenses of the plan for the 12-
6 month period referred to in subparagraph (B).
7 The income statement shall identify separately
8 the 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 HEALTH ACTU-
4 ARY.—The board of trustees of each association health
5 plan which provides benefits options in addition to health
6 insurance coverage and which is applying for certification
7 under this part or is certified under this part shall engage,
8 on behalf of all participants and beneficiaries, a qualified
9 health actuary who shall be responsible for the preparation
10 of the materials comprising information necessary to be
11 submitted by a qualified health actuary under this part.
12 The qualified health actuary shall utilize such assumptions
13 and techniques as are necessary to enable such actuary
14 to form an opinion as to whether the contents of the mat-
15 ters reported under this 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 health actuary shall be made
22 with respect to, and shall be made a part of, the annual
23 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 health actuary engaged by the plan, and such
11 actuary shall, not later than the end of the next following
12 month, make such recommendations to the board for cor-
13 rective action as the actuary determines necessary to en-
14 sure compliance with section 806. Not later than 30 days
15 after receiving from the actuary recommendations for cor-
16 rective actions, the board shall notify the applicable au-
17 thority (in such form and manner as the applicable au-
18 thority may prescribe by regulation) of such recommenda-
19 tions of the actuary for corrective action, together with
20 a description of the actions (if any) that the board has
21 taken or plans to take in response to such recommenda-
22 tions. The board shall thereafter report to the applicable
23 authority, in such form and frequency as the applicable
24 authority may specify to the board, regarding corrective

1 action taken by the board until the requirements of section
2 806 are met.

3 “(b) MANDATORY TERMINATION.—In any case in
4 which—

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

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

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

1 that the affairs of the plan will be, to the maximum extent
2 possible, wound up in a manner which will result in timely
3 provision of all benefits for which the plan is obligated.

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

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

1 continue until the conditions described in the first sen-
2 tence of this subsection are remedied or the plan is termi-
3 nated.

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

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

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

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

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

23 “(5) to collect for the plan any amounts due the
24 plan and to recover reasonable expenses of the trust-
25 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 2015.

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 HEALTH ACTUARY.—The
11 term ‘qualified health actuary’ means an individual
12 who is a member of the American Academy of Actu-
13 aries with expertise in health care.

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

16 “(A) a person who is otherwise eligible to
17 be a member of the sponsor but who elects an
18 affiliated status with the sponsor,

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

23 “(C) in the case of an association health
24 plan in existence on the date of the enactment
25 of the Small Business Health Fairness Act of

1 2015, 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 “(3) EXCEPTION FOR CERTAIN BENEFITS.—
22 The requirements of this part shall not apply to a
23 group health plan in relation to its provision of ex-
24 cepted benefits, as defined in section 706(c).”.

1 (b) CONFORMING AMENDMENTS TO PREEMPTION
2 RULES.—

3 (1) Section 514(b)(6) of such Act (29 U.S.C.
4 1144(b)(6)) is amended by adding at the end the
5 following new subparagraph:

6 “(E) The preceding subparagraphs of this paragraph
7 do not apply with respect to any State law in the case
8 of an association health plan which is certified under part
9 8.”.

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

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

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

22 (C) by redesignating subsection (d) as sub-
23 section (e); and

24 (D) by inserting after subsection (c) the
25 following new subsection:

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

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

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

22 “(B) In any case in which health insurance cov-
23 erage of any policy type is offered in a State under
24 an association health plan certified under part 8 and
25 the filing, with the applicable State authority (as de-

1 fined in section 812(a)(9)), of the policy form in
2 connection with such policy type is approved by such
3 State authority, the provisions of this title shall su-
4 percede any and all laws of any other State in which
5 health insurance coverage of such type is offered, in-
6 sofar as they may preclude, upon the filing in the
7 same form and manner of such policy form with the
8 applicable State authority in such other State, the
9 approval of the filing in such other State.

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

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

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

18 “(4) For additional provisions relating to association
19 health plans, see subsections (a)(2)(B) and (b) of section
20 805.

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

1 the meanings provided such terms in section 812, respec-
2 tively.”.

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

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

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

12 (C) by adding at the end the following new
13 clause:

14 “(iii) subject to subparagraph (E), in the case
15 of any other employee welfare benefit plan which is
16 a multiple employer welfare arrangement and which
17 provides medical care (within the meaning of section
18 733(a)(2)), any law of any State which regulates in-
19 surance may apply.”.

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

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

1 (B) by adding at the end the following new
2 paragraph:

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of the Small Busi-
5 ness Health Fairness Act of 2015 shall be construed to
6 alter, amend, modify, invalidate, impair, or supersede any
7 provision of this title, except by specific cross-reference to
8 the affected section.”.

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

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

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

1 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
 2 CATION OF SELF-INSURED ASSOCIATION HEALTH
 3 PLANS.—Not later than January 1, 2016, the Secretary
 4 of Labor shall report to the Committee on Education and
 5 the Workforce of the House of Representatives and the
 6 Committee on Health, Education, Labor, and Pensions of
 7 the Senate the effect association health plans have had,
 8 if any, on reducing the number of uninsured individuals.

9 (g) CLERICAL AMENDMENT.—The table of contents
 10 in section 1 of the Employee Retirement Income Security
 11 Act of 1974 is amended by inserting after the item relat-
 12 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.”.

13 **SEC. 213. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 14 **PLOYER ARRANGEMENTS.**

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

1 (1) in clause (i), by inserting after “control
2 group,” the following: “except that, in any case in
3 which the benefit referred to in subparagraph (A)
4 consists of medical care (as defined in section
5 812(a)(2)), two or more trades or businesses, wheth-
6 er or not incorporated, shall be deemed a single em-
7 ployer for any plan year of such plan, or any fiscal
8 year of such other arrangement, if such trades or
9 businesses are within the same control group during
10 such year or at any time during the preceding 1-year
11 period,”;

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

14 “(iii)(I) in any case in which the benefit re-
15 ferred to in subparagraph (A) consists of medical
16 care (as defined in section 812(a)(2)), the deter-
17 mination of whether a trade or business is under
18 ‘common control’ with another trade or business
19 shall be determined under regulations of the Sec-
20 retary applying principles consistent and coextensive
21 with the principles applied in determining whether
22 employees of two or more trades or businesses are
23 treated as employed by a single employer under sec-
24 tion 4001(b), except that, for purposes of this para-
25 graph, an interest of greater than 25 percent may

1 not be required as the minimum interest necessary
2 for common control, or

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

4 (3) by redesignating clauses (iv) and (v) as
5 clauses (v) and (vi), respectively; and

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

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

22 **SEC. 214. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
23 **CIATION HEALTH PLANS.**

24 (a) **CRIMINAL PENALTIES FOR CERTAIN WILLFUL**
25 **MISREPRESENTATIONS.**—Section 501 of the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. 1131)

2 is amended—

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

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

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

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

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

24 “(3) being a plan or arrangement described in
25 section 3(40)(A)(i),

1 shall, upon conviction, be imprisoned not more than 5
2 years, be fined under title 18, United States Code, or
3 both.”.

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

7 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
8 SIST ORDERS.—

9 “(1) IN GENERAL.—Subject to paragraph (2),
10 upon application by the Secretary showing the oper-
11 ation, promotion, or marketing of an association
12 health plan (or similar arrangement providing bene-
13 fits consisting of medical care (as defined in section
14 733(a)(2))) that—

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

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

1 a district court of the United States shall enter an
2 order requiring that the plan or arrangement cease
3 activities.

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

8 “(A) all benefits under it referred to in
9 paragraph (1) consist of health insurance cov-
10 erage; and

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

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

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

1 “(2) RECOGNITION OF PRIMARY DOMICILE
2 STATE.—In carrying out paragraph (1), the Sec-
3 retary shall ensure that only one State will be recog-
4 nized, with respect to any particular association
5 health plan, as the State with which consultation is
6 required. In carrying out this paragraph—

7 “(A) in the case of a plan which provides
8 health insurance coverage (as defined in section
9 812(a)(3)), such State shall be the State with
10 which filing and approval of a policy type of-
11 fered by the plan was initially obtained, and

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

17 **SEC. 216. EFFECTIVE DATE AND TRANSITIONAL AND**
18 **OTHER RULES.**

19 (a) EFFECTIVE DATE.—The amendments made by
20 this subtitle shall take effect 1 year after the date of the
21 enactment of this Act. The Secretary of Labor shall first
22 issue all regulations necessary to carry out the amend-
23 ments made by this subtitle within 1 year after the date
24 of the enactment of this Act.

1 (b) TREATMENT OF CERTAIN EXISTING HEALTH
2 BENEFITS PROGRAMS.—

3 (1) IN GENERAL.—In any case in which, as of
4 the date of the enactment of this Act, an arrange-
5 ment is maintained in a State for the purpose of
6 providing benefits consisting of medical care for the
7 employees and beneficiaries of its participating em-
8 ployers, at least 200 participating employers make
9 contributions to such arrangement, such arrange-
10 ment has been in existence for at least 10 years, and
11 such arrangement is licensed under the laws of one
12 or more States to provide such benefits to its par-
13 ticipating employers, upon the filing with the appli-
14 cable authority (as defined in section 812(a)(5) of
15 the Employee Retirement Income Security Act of
16 1974 (as amended by this subtitle)) by the arrange-
17 ment of an application for certification of the ar-
18 rangement under part 8 of subtitle B of title I of
19 such Act—

20 (A) such arrangement shall be deemed to
21 be a group health plan for purposes of title I
22 of such Act;

23 (B) the requirements of sections 801(a)
24 and 803(a) of the Employee Retirement Income

1 Security Act of 1974 shall be deemed met with
2 respect to such arrangement;

3 (C) the requirements of section 803(b) of
4 such Act shall be deemed met, if the arrange-
5 ment is operated by a board of directors
6 which—

7 (i) is elected by the participating em-
8 ployers, with each employer having one
9 vote; and

10 (ii) has complete fiscal control over
11 the arrangement and which is responsible
12 for all operations of the arrangement;

13 (D) the requirements of section 804(a) of
14 such Act shall be deemed met with respect to
15 such arrangement; and

16 (E) the arrangement may be certified by
17 any applicable authority with respect to its op-
18 erations in any State only if it operates in such
19 State on the date of certification.

20 The provisions of this subsection shall cease to apply
21 with respect to any such arrangement at such time
22 after the date of the enactment of this Act as the
23 applicable requirements of this subsection are not
24 met with respect to such arrangement.

1 (2) DEFINITIONS.—For purposes of this sub-
2 section, the terms “group health plan”, “medical
3 care”, and “participating employer” shall have the
4 meanings provided in section 812 of the Employee
5 Retirement Income Security Act of 1974, except
6 that the reference in paragraph (7) of such section
7 to an “association health plan” shall be deemed a
8 reference to an arrangement referred to in this sub-
9 section.

10 **Subtitle C—Health Insurance** 11 **Reforms**

12 **SEC. 221. REQUIREMENTS FOR INDIVIDUAL HEALTH INSUR-** 13 **ANCE.**

14 (a) IN GENERAL.—Section 2741 of the Public Health
15 Service Act (42 U.S.C. 300gg–41), as restored and revived
16 by section 2 of this Act, is amended—

17 (1) in subsection (a)—

18 (A) in the heading, by striking “to certain
19 individuals with prior group coverage”;

20 (B) in paragraph (1), by striking “and sec-
21 tion 2744”;

22 (C) in paragraph (1)(B), by inserting “un-
23 less such exclusion complies with paragraph
24 (2)” before the period; and

1 (D) by striking paragraph (2) and insert-
2 ing the following new paragraphs:

3 “(2) LIMITATION ON PREEXISTING CONDITION
4 EXCLUSION PERIOD.—

5 “(A) LIMITATION.—A health insurance
6 issuer offering health insurance coverage in the
7 individual market may not, with respect to an
8 enrollee in such coverage, impose any pre-
9 existing condition exclusion if such enrollee has
10 at least 18 months of continuous creditable cov-
11 erage (as defined in section 2701(c)(1)) imme-
12 diately preceding the enrollment date.

13 “(B) IMPOSITION OF EXCLUSION.—Not-
14 withstanding paragraph (1)(B), a health insur-
15 ance issuer offering health insurance coverage
16 in the individual market may, with respect to
17 an enrollee in such coverage who is not de-
18 scribed in subparagraph (A), impose a pre-
19 existing condition exclusion only if—

20 “(i) such exclusion relates to a condi-
21 tion (whether physical or mental), regard-
22 less of the cause of the condition, for which
23 medical advice, diagnosis, care, or treat-
24 ment was recommended or received within

1 the 6-month period ending on the enroll-
2 ment date;

3 “(ii) such exclusion extends for a pe-
4 riod of not more than 18 months after the
5 enrollment date; and

6 “(iii) the period of any such pre-
7 existing condition exclusion is reduced by
8 the aggregate of the periods of creditable
9 coverage (if any, as defined in section
10 2701(c)(1)) applicable to the enrollee as of
11 the enrollment date.

12 “(C) PREMIUM SURCHARGE.—Notwith-
13 standing paragraph (6), with respect to an en-
14 rollee described in subparagraph (B), a health
15 insurance issuer may charge a premium for the
16 coverage involved that does not exceed 150 per-
17 cent of the applicable standard rate, for not to
18 exceed 24 months (or 36 months if the health
19 insurance issuer does not impose any pre-
20 existing condition exclusion with respect to such
21 enrollee), reduced by the aggregate of the peri-
22 ods of creditable coverage (if any, as defined in
23 section 2701(c)(1)) applicable to the enrollee as
24 of the enrollment date. For purposes of this
25 subsection, the term ‘applicable standard rate’

1 means the standard premium rate that the
2 issuer charges for the coverage involved with re-
3 spect to an individual described in subpara-
4 graph (A) with the same rating characteristics
5 or rating factors as the enrollee described in
6 subparagraph (B), provided that any variations
7 in standard premium rates are based on the
8 uniform application of rating characteristics or
9 rating factors that are permitted by State law
10 and are not otherwise prohibited by paragraph
11 (6).

12 “(3) EXCEPTIONS.—Notwithstanding para-
13 graph (2), and subject to subparagraph (D), a
14 health insurance issuer offering health insurance
15 coverage in the individual market, may not impose
16 any of the following preexisting condition exclusion:

17 “(A) EXCLUSION NOT APPLICABLE TO
18 CERTAIN NEWBORNS.—In the case of an indi-
19 vidual who, as of the last day of the 30-day pe-
20 riod beginning with the date of birth, is a de-
21 pendent of an enrollee in such coverage.

22 “(B) EXCLUSION NOT APPLICABLE TO
23 CERTAIN ADOPTED CHILDREN.—In the case of
24 a child who is adopted or placed for adoption
25 before attaining 18 years of age and who, as of

1 the last day of the 30-day period beginning on
2 the date of the adoption or placement for adop-
3 tion, is a dependent of an enrollee in such cov-
4 erage. The previous sentence shall not apply to
5 coverage before the date of such adoption or
6 placement for adoption.

7 “(C) EXCLUSION NOT APPLICABLE TO
8 PREGNANCY.—Relating to pregnancy as a pre-
9 existing condition.

10 “(D) LOSS IF BREAK IN COVERAGE.—Sub-
11 paragraphs (A) and (B) shall no longer apply
12 to an individual after the end of the first 63-
13 day period during all of which the individual
14 was not covered under any creditable coverage.

15 “(4) OPEN ENROLLMENT PERIODS.—A health
16 insurance issuer offering health insurance coverage
17 in the individual market may limit the applicability
18 of the provisions of paragraph (1) to scheduled open
19 enrollment periods, provided that—

20 “(A) any such open enrollment period shall
21 not be less than 30 days;

22 “(B) any period between scheduled open
23 enrollment periods shall not exceed 24 months;
24 and

1 “(C) such limitation shall not apply to any
2 individual who qualifies for a special enrollment
3 period under paragraph (5).

4 “(5) SPECIAL ENROLLMENT PERIODS.—Subject
5 to subparagraphs (E) and (F), a health insurance
6 issuer offering health insurance coverage in the indi-
7 vidual market shall permit an individual who is an
8 eligible individual or a dependent to enroll in cov-
9 erage during a special enrollment period if the indi-
10 vidual experiences any of the following qualifying
11 events:

12 “(A) FOR DEPENDENT BENEFICIARIES.—
13 The individual becomes, by reason of marriage,
14 birth, adoption or placement for adoption, a de-
15 pendent of an individual enrolled in a plan of-
16 fered by the health insurance issuer and such
17 individual otherwise qualifies, under the terms
18 of the plan, as eligible for coverage as a depend-
19 ent of such enrollee.

20 “(B) LOSS OF GROUP COVERAGE.—The in-
21 dividual loses coverage under a group health
22 plan as a result of—

23 “(i) loss of eligibility for the coverage
24 (including as a result of legal separation,
25 divorce, death, attaining an age at which

1 eligibility terminates, termination of em-
2 ployment, or reduction in the number of
3 hours of employment); or

4 “(ii) termination of the coverage by
5 the plan sponsor.

6 “(C) LOSS OF INDIVIDUAL COVERAGE.—

7 The individual loses individual market coverage
8 as a result of—

9 “(i) discontinuation of a plan as a re-
10 sult of a health insurance issuer ceasing to
11 offer coverage in the individual market in
12 accordance with section 2742(c)(2) (42
13 U.S.C. 300gg-42(c)(2)) of this title;

14 “(ii) expiration of COBRA, or other,
15 continuation coverage;

16 “(iii) ceasing to qualify, under the
17 terms of the coverage, as a dependent (in-
18 cluding as a result of legal separation, di-
19 vorce, death, or attaining an age at which
20 eligibility terminates); and

21 “(iv) permanently moving outside the
22 State in which the coverage was issued, or
23 in the case of a network plan, outside the
24 plan’s service area.

1 “(D) LOSS OF ELIGIBILITY FOR A GOV-
2 ERNMENT COVERAGE PROGRAM.—The indi-
3 vidual loses coverage by ceasing to be eligible
4 for coverage under any of the following:

5 “(i) Part A or part B of title XVIII
6 of the Social Security Act (42 U.S.C.
7 1395c et seq., 1395j et seq.).

8 “(ii) Title XIX of the Social Security
9 Act (42 U.S.C. 1396 et seq.), other than
10 coverage consisting solely of benefits under
11 section 1928 (42 U.S.C. 1396s).

12 “(iii) Title XXI of the Social Security
13 Act (42 U.S.C. 1397aa et seq.).

14 “(iv) Chapter 55 of title 10.

15 “(v) Chapter 89 of title 5.

16 “(vi) A State health benefits risk pool.

17 “(E) For purposes of this paragraph, loss
18 of coverage shall not include any of the fol-
19 lowing:

20 “(i) Voluntary termination of coverage
21 by an individual, except if such termination
22 is the result of circumstances described in
23 subparagraph (C)(iv).

24 “(ii) Termination of coverage by the
25 issuer or the plan sponsor of the coverage

1 for any reason described in paragraphs (1)
2 or (2) of section 2742(b) (300gg-42(b)) of
3 this title.

4 “(iii) Loss of any coverage that con-
5 sists solely of coverage of excepted benefits
6 (as defined in section 300gg-91(c) of this
7 title).

8 “(F) Any special enrollment period shall
9 not be less than 60 days and shall begin on the
10 date of the qualifying event.

11 “(6) STANDARD PREMIUM RATES.—With re-
12 spect to the premium rate charged by a health insur-
13 ance issuer for health insurance coverage offered in
14 the individual market, such rate, with respect to the
15 particular plan or coverage involved, shall not vary
16 based on any of the following health status-related
17 factors in relation to an eligible individual or de-
18 pendent:

19 “(A) Health status.

20 “(B) Medical condition (including both
21 physical and mental illnesses).

22 “(C) Claims experience.

23 “(D) Receipt of health care.

24 “(E) Medical history.

25 “(F) Genetic information.

1 “(G) Evidence of insurability (including
2 conditions arising out of acts of domestic vio-
3 lence).

4 “(H) Disability.”;

5 (2) by amending subsection (b) to read as fol-
6 lows:

7 “(b) DEFINITIONS.—For purposes of this section:

8 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
9 individual’ means an individual who is eligible under
10 applicable State law to purchase individual health in-
11 surance coverage in the State.

12 “(2) DEPENDENT.—The term ‘dependent’
13 means an individual who, under the terms of the
14 coverage and applicable State law, qualifies to enroll
15 in such coverage as a dependent of an individual de-
16 scribed in paragraph (1).”; and

17 (3) by striking subsection (c) and redesignating
18 subsection (d) and the first subsection (e) as sub-
19 sections (c) and (d), respectively.

20 (b) CONFORMING AMENDMENT.—Section 2744 of the
21 Public Health Service Act (42 U.S.C. 300gg–44), as re-
22 stored and revived by section 2 of this Act, is repealed.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall apply with respect to health insurance

1 coverage offered for plan years beginning after the date
2 of the enactment of this Act.

3 **TITLE III—INTERSTATE MARKET**
4 **FOR HEALTH INSURANCE**

5 **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**
6 **HEALTH INSURANCE COVERAGE.**

7 (a) IN GENERAL.—Title XXVII of the Public Health
8 Service Act (42 U.S.C. 300gg et seq.), as restored by sec-
9 tion 2, is amended by adding at the end the following new
10 part:

11 **“PART D—COOPERATIVE GOVERNING OF**
12 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

13 **“SEC. 2795. DEFINITIONS.**

14 “In this part:

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

1 once the policy is issued, except that such a change
2 may be made upon renewal of the policy. With re-
3 spect to such designated State, the issuer is deemed
4 to be doing business in that State.

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

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

19 “(4) INDIVIDUAL HEALTH INSURANCE COV-
20 ERAGE.—The term ‘individual health insurance cov-
21 erage’ means health insurance coverage offered in
22 the individual market, as defined in section
23 2791(e)(1), but does not include excepted benefits
24 described in section 2791(c).

1 “(5) APPLICABLE STATE AUTHORITY.—The
2 term ‘applicable State authority’ means, with respect
3 to a health insurance issuer in a State, the State in-
4 surance commissioner or official or officials des-
5 ignated by the State to enforce the requirements of
6 this title for the State with respect to the issuer.

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

12 “(A) to meet obligations to policyholders
13 with respect to known claims and reasonably
14 anticipated claims; or

15 “(B) to pay other obligations in the normal
16 course of business.

17 “(7) COVERED LAWS.—

18 “(A) IN GENERAL.—The term ‘covered
19 laws’ means the laws, rules, regulations, agree-
20 ments, and orders governing the insurance busi-
21 ness pertaining to—

22 “(i) individual health insurance cov-
23 erage issued by a health insurance issuer;

24 “(ii) the offer, sale, rating (including
25 medical underwriting), renewal, and

1 issuance of individual health insurance cov-
2 erage to an individual;

3 “(iii) the provision to an individual in
4 relation to individual health insurance cov-
5 erage of health care and insurance related
6 services;

7 “(iv) the provision to an individual in
8 relation to individual health insurance cov-
9 erage of management, operations, and in-
10 vestment activities of a health insurance
11 issuer; and

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

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

1 “(8) STATE.—The term ‘State’ means only the
2 50 States and the District of Columbia.

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

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

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

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

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

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

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

24 “(G) A pattern or practice of compelling
25 insured individuals or their beneficiaries to in-

1 stitute suits to recover amounts due under its
2 policies by offering substantially less than the
3 amounts ultimately recovered in suits brought
4 by them.

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

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

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

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

23 “(10) FRAUD AND ABUSE.—The term ‘fraud
24 and abuse’ means an act or omission committed by
25 a person who, knowingly and with intent to defraud,

1 commits, or conceals any material information con-
2 cerning, one or more of the following:

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

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

12 “(ii) The rating of an insurance policy
13 or reinsurance contract.

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

17 “(iv) Premiums paid on an insurance
18 policy or reinsurance contract.

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

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

1 “(vii) The financial condition of an in-
2 surer or reinsurer.

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

8 “(ix) The issuance of written evidence
9 of insurance.

10 “(x) The reinstatement of an insur-
11 ance policy.

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

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

23 “(D) Attempt to commit, aiding or abet-
24 ting in the commission of, or conspiracy to com-

1 mit the acts or omissions specified in this para-
2 graph.

3 **“SEC. 2796. APPLICATION OF LAW.**

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

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

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

23 “(A) to pay, on a nondiscriminatory basis,
24 applicable premium and other taxes (including
25 high-risk pool assessments) which are levied on

1 insurers and surplus lines insurers, brokers, or
2 policyholders under the laws of the State;

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

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

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

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

23 “(D) to comply with a lawful order
24 issued—

1 “(i) in a delinquency proceeding com-
2 menced by the State insurance commis-
3 sioner if there has been a finding of finan-
4 cial impairment under subparagraph (C);
5 or

6 “(ii) in a voluntary dissolution pro-
7 ceeding;

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

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

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

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

4 “(I) to comply with the applicable require-
5 ments for independent review under section
6 2798 with respect to coverage offered in the
7 State;

8 “(2) require any individual health insurance
9 coverage issued by the issuer to be countersigned by
10 an insurance agent or broker residing in that Sec-
11 ondary State; or

12 “(3) otherwise discriminate against the issuer
13 issuing insurance in both the primary State and in
14 any secondary State.

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

1 This policy is issued by _____ and is governed by
2 the laws and regulations of the State of _____, and
3 it has met all the laws of that State as determined by
4 that State’s Department of Insurance. This policy may be
5 less expensive than others because it is not subject to all
6 of the insurance laws and regulations of the State of
7 _____, including coverage of some services or bene-
8 fits mandated by the law of the State of _____. Ad-
9 ditionally, this policy is not subject to all of the consumer
10 protection laws or restrictions on rate changes of the State
11 of _____. As with all insurance products, before pur-
12 chasing this policy, you should carefully review the policy
13 and determine what health care services the policy covers
14 and what benefits it provides, including any exclusions,
15 limitations, or conditions for such services or benefits.

16 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
17 AND PREMIUM INCREASES.—

18 “(1) IN GENERAL.—For purposes of this sec-
19 tion, a health insurance issuer that provides indi-
20 vidual health insurance coverage to an individual
21 under this part in a primary or secondary State may
22 not upon renewal—

23 “(A) move or reclassify the individual in-
24 sured under the health insurance coverage from
25 the class such individual is in at the time of

1 issue of the contract based on the health-status
2 related factors of the individual; or

3 “(B) increase the premiums assessed the
4 individual for such coverage based on a health
5 status-related factor or change of a health sta-
6 tus-related factor or the past or prospective
7 claim experience of the insured individual.

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

11 “(A) from terminating or discontinuing
12 coverage or a class of coverage in accordance
13 with subsections (b) and (c) of section 2742;

14 “(B) from raising premium rates for all
15 policy holders within a class based on claims ex-
16 perience;

17 “(C) from changing premiums or offering
18 discounted premiums to individuals who engage
19 in wellness activities at intervals prescribed by
20 the issuer, if such premium changes or incen-
21 tives—

22 “(i) are disclosed to the consumer in
23 the insurance contract;

1 “(ii) are based on specific wellness ac-
2 tivities that are not applicable to all indi-
3 viduals; and

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

6 “(D) from reinstating lapsed coverage; or

7 “(E) from retroactively adjusting the rates
8 charged an insured individual if the initial rates
9 were set based on material misrepresentation by
10 the individual at the time of issue.

11 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
12 STATE.—A health insurance issuer may not offer for sale
13 individual health insurance coverage in a secondary State
14 unless that coverage is currently offered for sale in the
15 primary State.

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

1 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
2 SURANCE COMMISSIONER.—Each health insurance issuer
3 issuing individual health insurance coverage in both pri-
4 mary and secondary States shall submit—

5 “(1) to the insurance commissioner of each
6 State in which it intends to offer such coverage, be-
7 fore it may offer individual health insurance cov-
8 erage in such State—

9 “(A) a copy of the plan of operation or fea-
10 sibility study or any similar statement of the
11 policy being offered and its coverage (which
12 shall include the name of its primary State and
13 its principal place of business);

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

16 “(C) written notice from the issuer of the
17 issuer’s compliance with all the laws of the pri-
18 mary State; and

19 “(2) to the insurance commissioner of each sec-
20 ondary State in which it offers individual health in-
21 surance coverage, a copy of the issuer’s quarterly fi-
22 nancial statement submitted to the primary State,
23 which statement shall be certified by an independent
24 public accountant and contain a statement of opin-

1 ion on loss and loss adjustment expense reserves
2 made by—

3 “(A) a member of the American Academy
4 of Actuaries; or

5 “(B) a qualified loss reserve specialist.

6 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—

7 Nothing in this section shall be construed to affect the
8 authority of any Federal or State court to enjoin—

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

13 “(2) the solicitation or sale of individual health
14 insurance coverage that violates the requirements of
15 the law of a secondary State which are described in
16 subparagraphs (A) through (H) of section
17 2796(b)(1).

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

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

24 “(1) IN GENERAL.—Subject to the provisions of
25 subsection (b)(1)(G) (relating to injunctions) and

1 paragraph (2), nothing in this section shall be con-
2 strued to affect the authority of any State to make
3 use of any of its powers to enforce the laws of such
4 State with respect to which a health insurance issuer
5 is not exempt under subsection (b).

6 “(2) COURTS OF COMPETENT JURISDICTION.—
7 If a State seeks an injunction regarding the conduct
8 described in paragraphs (1) and (2) of subsection
9 (h), such injunction must be obtained from a Fed-
10 eral or State court of competent jurisdiction.

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

14 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
15 this section shall be construed to affect the applicability
16 of State laws generally applicable to persons or corpora-
17 tions.

18 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
19 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
20 health insurance issuer is offering coverage in a primary
21 State that does not accommodate residents of secondary
22 States or does not provide a working mechanism for resi-
23 dents of a secondary State, and the issuer is offering cov-
24 erage under this part in such secondary State which has
25 not adopted a qualified high-risk pool as its acceptable al-

1 ternative mechanism (as defined in section 2744(c)(2)),
2 the issuer shall, with respect to any individual health in-
3 surance coverage offered in a secondary State under this
4 part, comply with the guaranteed availability requirements
5 for eligible individuals in section 2741.

6 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
7 **BEFORE ISSUER MAY SELL INTO SECONDARY**
8 **STATES.**

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

15 **“SEC. 2798. LIMITATION ON INDIVIDUAL PURCHASE IN SEC-**
16 **ONDARY STATE.**

17 “Effective beginning two years after the date of en-
18 actment of this part, an individual in a State may not
19 buy individual health insurance coverage in a secondary
20 State if the premium for individual health insurance in
21 the primary State (with respect to the individual) exceeds
22 the national average premium by 10 percent or more.

1 **“SEC. 2799. INDEPENDENT EXTERNAL APPEALS PROCE-**
2 **DURES.**

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

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

12 “(2) in any case in which the requirements of
13 paragraph (1) are not met with respect to the either
14 of such States, the issuer provides an independent
15 review mechanism substantially identical (as deter-
16 mined by the applicable State authority of such
17 State) to that prescribed in the ‘Health Carrier Ex-
18 ternal Review Model Act’ of the National Association
19 of Insurance Commissioners for all individuals who
20 purchase insurance coverage under the terms of this
21 part, except that, under such mechanism, the review
22 is conducted by an independent medical reviewer, or
23 a panel of such reviewers, with respect to whom the
24 requirements of subsection (b) are met.

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

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

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

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

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

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

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

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

4 “(3) INDEPENDENCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 **“SEC. 2800. ENFORCEMENT.**

2 “(a) IN GENERAL.—Subject to subsection (b), with
3 respect to specific individual health insurance coverage the
4 primary State for such coverage has sole jurisdiction to
5 enforce the primary State’s covered laws in the primary
6 State and any secondary State.

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

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

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

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

25 (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

23 (d) SEVERABILITY.—If any provision of the section
24 or the application of such provision to any person or cir-
25 cumstance is held to be unconstitutional, the remainder

1 of this section and the application of the provisions of such
2 to any other person or circumstance shall not be affected.

3 **TITLE IV—LAWSUIT ABUSE**
4 **REFORMS**

5 **SEC. 401. CHANGE IN BURDEN OF PROOF BASED ON COM-**
6 **PLIANCE WITH CLINICAL PRACTICE GUIDE-**
7 **LINES.**

8 (a) SELECTION AND ISSUANCE OF CLINICAL PRAC-
9 TICES GUIDELINES.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services (in this section referred to as the
12 “Secretary”) shall provide for the selection and
13 issuance of clinical practice guidelines for treatment
14 of medical conditions (each in this subsection re-
15 ferred to as a “guideline”) in accordance with para-
16 graphs (2) and (3).

17 (2) DEVELOPMENT PROCESS.—Not later than
18 90 days after the date of enactment of this title, the
19 Secretary shall enter into a contract with a qualified
20 physician consensus-building organization (such as
21 the Physician Consortium for Performance Improve-
22 ment), in concert and agreement with physician spe-
23 cialty organizations, to develop guidelines. The con-
24 tract shall require that the organization submit

1 guidelines to the agency not later than 18 months
2 after the date of the enactment of this title.

3 (3) ISSUANCE.—

4 (A) IN GENERAL.—Not later than 2 years
5 after the date of the enactment of this title, the
6 Secretary shall, after notice and opportunity for
7 public comment, make a rule that provides for
8 the issuance of the guidelines submitted under
9 paragraph (2).

10 (B) LIMITATION.—The Secretary may not
11 make a rule that includes guidelines other than
12 those submitted under paragraph (2).

13 (C) DISSEMINATION.—The Secretary shall
14 post such guidelines on the public Internet Web
15 page of the Department of Health and Human
16 Services.

17 (4) MAINTENANCE.—Not later than 4 years
18 after the date of enactment of this title, and every
19 2 years thereafter, the Secretary shall review the
20 guidelines and shall, as necessary, enter into con-
21 tracts similar to the contract described in paragraph
22 (2), and issue guidelines in a manner similar to the
23 issuance of guidelines under paragraph (3).

24 (b) USE.—

1 (1) USE BY DEFENDANT TO CHANGE THE BUR-
2 DEN OF PROOF.—If a defendant in a health care
3 lawsuit relating to treatment of an individual estab-
4 lishes by a preponderance of the evidence that the
5 treatment was provided in a manner consistent with
6 an applicable guideline issued under subsection (a),
7 the defendant may not be held liable unless the
8 plaintiff establishes the liability of the defendant by
9 clear and convincing evidence.

10 (2) LIMITATION ON INTRODUCTION AS EVI-
11 DENCE AGAINST A DEFENDANT.—Guidelines issued
12 under subsection (a) may not be introduced as evi-
13 dence of negligence or deviation in the standard of
14 care in any health care lawsuit unless they have pre-
15 viously been introduced by the defendant.

16 (3) NO PRESUMPTION OF NEGLIGENCE AGAINST
17 A DEFENDANT.—There shall be no presumption of
18 negligence with respect to treatment if a health care
19 provider provides the treatment in a manner incon-
20 sistent with such guidelines.

21 (c) CONSTRUCTION.—Nothing in this section shall be
22 construed as preventing a State from—

23 (1) replacing their current medical malpractice
24 rules with rules that rely, as a defense, upon a

1 health care provider’s compliance with a guideline
2 issued under subsection (a); or

3 (2) applying additional guidelines or limitations
4 on liability that are in addition to, but not in lieu
5 of, the guidelines issued under subsection (a).

6 **SEC. 402. STATE GRANTS TO CREATE EXPERT PANELS AND**
7 **ADMINISTRATIVE HEALTH CARE TRIBUNALS.**

8 Part P of title III of the Public Health Service Act
9 (42 U.S.C. 280g et seq.) is amended by adding at the end
10 the following:

11 **“SEC. 399T. STATE GRANTS TO CREATE ADMINISTRATIVE**
12 **HEALTH CARE TRIBUNALS.**

13 “(a) IN GENERAL.—The Secretary may award grants
14 to States for the development, implementation, and eval-
15 uation of administrative health care tribunals that comply
16 with this section, for the resolution of disputes concerning
17 injuries allegedly caused by health care providers.

18 “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—
19 To be eligible to receive a grant under this section, a State
20 shall submit to the Secretary an application at such time,
21 in such manner, and containing such information as may
22 be required by the Secretary. A grant shall be awarded
23 under this section on such terms and conditions as the
24 Secretary determines appropriate.

1 “(c) REPRESENTATION BY COUNSEL.—A State that
2 receives a grant under this section may not preclude any
3 party to a dispute before an administrative health care tri-
4 bunal operated under such grant from obtaining legal rep-
5 resentation during any review by the expert panel under
6 subsection (d), the administrative health care tribunal
7 under subsection (e), or a State court under subsection
8 (f).

9 “(d) EXPERT PANEL REVIEW AND EARLY OFFER
10 GUIDELINES.—

11 “(1) IN GENERAL.—If, in any health care liabil-
12 ity action against a health care provider, the health
13 care provider alleges, in any response to the claim-
14 ant’s filing, that the health care provider adhered to
15 an applicable practice guideline in the provision of
16 health care items or services to the claimant, then
17 further proceedings on the health care liability ac-
18 tion shall be suspended prior to discovery pro-
19 ceedings, until the completion of a review of the ac-
20 tion by an independent expert panel in accordance
21 with this subsection.

22 “(2) COMPOSITION.—

23 “(A) IN GENERAL.—The members of each
24 expert panel under this subsection shall be ap-
25 pointed by the head of the State agency respon-

1 sible for health. Each expert panel shall be
2 composed of no fewer than 3 members and not
3 more than 5 members. At least one-half of such
4 members shall be medical experts (either physi-
5 cians or health care professionals).

6 “(B) LICENSURE AND EXPERTISE.—Each
7 physician or health care professional appointed
8 to an expert panel under subparagraph (A)
9 shall—

10 “(i) be appropriately credentialed or
11 licensed in one or more States to deliver
12 health care services; and

13 “(ii) typically treat the condition,
14 make the diagnosis, or provide the type of
15 treatment that is under review.

16 “(C) INDEPENDENCE.—

17 “(i) IN GENERAL.—Subject to clause
18 (ii), each individual appointed to an expert
19 panel under this paragraph shall—

20 “(I) not have a material familial,
21 financial, or professional relationship
22 with a party involved in the dispute
23 reviewed by the panel; and

24 “(II) not otherwise have a con-
25 flict of interest with such a party.

1 “(ii) EXCEPTION.—Nothing in clause
2 (i) shall be construed to prohibit an indi-
3 vidual who has staff privileges at an insti-
4 tution where the treatment involved in the
5 dispute was provided from serving as a
6 member of an expert panel merely on the
7 basis of such affiliation, if the affiliation is
8 disclosed to the parties and neither party
9 objects.

10 “(D) PRACTICING HEALTH CARE PROFES-
11 SIONAL IN SAME FIELD.—

12 “(i) IN GENERAL.—In a dispute be-
13 fore an expert panel that involves treat-
14 ment, or the provision of items or serv-
15 ices—

16 “(I) by a physician, the medical
17 experts on the expert panel shall be
18 practicing physicians (allopathic or os-
19 teopathic) of the same or similar spe-
20 cialty as a physician who typically
21 treats the condition, makes the diag-
22 nosis, or provides the type of treat-
23 ment under review; or

24 “(II) by a health care profes-
25 sional other than a physician, at least

1 two medical experts on the expert
2 panel shall be practicing physicians
3 (allopathic or osteopathic) of the same
4 or similar specialty as the health care
5 professional who typically treats the
6 condition, makes the diagnosis, or
7 provides the type of treatment under
8 review, and, if determined appropriate
9 by the State agency, an additional
10 medical expert shall be a practicing
11 health care professional (other than
12 such a physician) of such a same or
13 similar specialty.

14 “(ii) PRACTICING DEFINED.—In this
15 paragraph, the term ‘practicing’ means,
16 with respect to an individual who is a phy-
17 sician or other health care professional,
18 that the individual provides health care
19 services to individual patients on average
20 at least 2 days a week.

21 “(E) PEDIATRIC EXPERTISE.—In the case
22 of dispute relating to a child, at least 1 medical
23 expert on the expert panel shall have expertise
24 described in subparagraph (D)(i) in pediatrics.

1 “(F) NO CIVIL LIABILITY FOR MEM-
2 BERS.—No civil action shall be brought in any
3 court against any member of an expert panel
4 for any act done, failure to act, or statement or
5 opinion made, within the scope of individual’s
6 as a member of the expert panel.

7 “(3) DETERMINATION.—

8 “(A) IN GENERAL.—After a review under
9 paragraph (1), an expert panel shall make a de-
10 termination as to the liability of the parties in-
11 volved and compensation.

12 “(B) CONSIDERATIONS IN MAKING DETER-
13 MINATIONS.—In making a determination under
14 this subsection as to the liability of parties in-
15 volved and compensation, the following shall
16 apply:

17 “(i) TREATMENT OF CLINICAL PRAC-
18 TICE GUIDELINES.—An expert panel shall
19 acknowledge the ability of physicians to de-
20 part from the recommendations in clinical
21 practice guidelines, when appropriate, in
22 the care of individual patients.

23 “(ii) LIMITATION.—An expert panel
24 shall not make a finding of negligence
25 from the mere fact that a treatment or

1 procedure was unsuccessful or failed to
2 bring the best result.

3 “(4) EARLY OFFER.—If the parties to a dispute
4 before an expert panel under this subsection accept
5 the determination of the expert panel concerning li-
6 ability and compensation, such compensation shall
7 be paid to the claimant and the claimant shall agree
8 to forgo any further action against the health care
9 providers involved.

10 “(5) FAILURE TO ACCEPT.—If any party de-
11 cides not to accept the expert panel’s determination,
12 the matter shall be referred to an administrative
13 health care tribunal created pursuant to this section.

14 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

15 “(1) IN GENERAL.—Upon the failure of any
16 party to accept the determination of an expert panel
17 under subsection (d), the parties shall have the right
18 to request a hearing concerning the liability or com-
19 pensation involved by an administrative health care
20 tribunal established by the State involved.

21 “(2) REQUIREMENTS.—In establishing an ad-
22 ministrative health care tribunal under this section,
23 a State shall—

1 “(A) ensure that such tribunals are pre-
2 sided over by special judges with health care ex-
3 pertise;

4 “(B) provide authority to such judges to
5 make binding rulings, rendered in written deci-
6 sions, on standards of care, causation, com-
7 pensation, and related issues with reliance on
8 independent expert witnesses commissioned by
9 the tribunal;

10 “(C) establish gross negligence as the legal
11 standard for the tribunal; and

12 “(D) allow the admission into evidence of
13 the recommendation made by the expert panel
14 under subsection (d).

15 “(f) REVIEW BY STATE COURT AFTER EXHAUSTION
16 OF ADMINISTRATIVE REMEDIES.—

17 “(1) RIGHT TO FILE.—If any party to a dispute
18 before a health care tribunal under subsection (e) is
19 not satisfied with the determinations of the tribunal,
20 the party shall have the right to file their claim in
21 a State court of competent jurisdiction.

22 “(2) FORFEIT OF AWARDS.—Any party filing
23 an action in a State court in accordance with para-
24 graph (1) shall forfeit any compensation award
25 made under subsection (e).

1 “(3) ADMISSIBILITY.—The determinations of
2 the expert panel and the administrative health care
3 tribunal pursuant to subsections (d) and (e) with re-
4 spect to a State court proceeding under paragraph
5 (1) shall be admissible into evidence in any such
6 State court proceeding.

7 “(4) TREATMENT OF CERTAIN EXPERT PANEL
8 AND ADMINISTRATIVE HEALTH CARE TRIBUNAL
9 FINDINGS.—

10 “(A) WORK PRODUCT.—No finding by an
11 expert panel under subsection (d) or adminis-
12 trative health care tribunal under subsection (e)
13 that the defendant applicable eligible profes-
14 sional breached the standard of care as set
15 forth under the prescribed practice guidelines
16 shall constitute negligence per se or conclusive
17 evidence of liability.

18 “(B) FINDING RELATING TO CLINICAL
19 PRACTICE GUIDELINES.—If an administrative
20 health care tribunal did not make a finding
21 under subsection (e) that there was an applica-
22 ble clinical practice guideline that the defendant
23 adhered to, with respect to the State court pro-
24 ceeding under paragraph (1) the State court
25 may issue summary judgment in favor of the

1 defendant health care professional unless the
2 claimant is able to show otherwise by clear and
3 convincing evidence. If an administrative health
4 care tribunal made a finding under subsection
5 (e) that there was an applicable clinical practice
6 guideline that the defendant adhered to, with
7 respect to a State court proceeding under para-
8 graph (1) the State court shall issue summary
9 judgment in favor of the applicable health care
10 professional unless the claimant is able to show
11 otherwise by clear and convincing evidence.

12 “(C) FINDING RELATING TO STANDARD OF
13 CARE.—Any finding an expert panel or adminis-
14 trative health care tribunal under subsection (d)
15 or (e), respectively, that the defendant did not
16 breach the standard of care as set forth under
17 the prescribed clinical practice guidelines or
18 that the defendant’s failure to conform to the
19 required standard was neither the cause in fact
20 nor the proximate cause of the plaintiff’s injury
21 or that the plaintiff did not incur any damages
22 as a result shall be given deference by the State
23 court involved and shall entitle the defendant to
24 summary judgment unless the plaintiff is able
25 to show by clear and convincing evidence that

1 the expert panel or health care tribunal, respec-
2 tively, was in error and that there is a genuine
3 issue as to a material fact in the case.

4 “(g) DEFINITION.—In this section, the term ‘health
5 care provider’ means any person or entity required by
6 State or Federal laws or regulations to be licensed, reg-
7 istered, or certified to provide health care services, and
8 being either so licensed, registered, or certified, or exempt-
9 ed from such requirement by other statute or regulation.

10 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated for any fiscal year such
12 sums as may be necessary for purposes of making grants
13 to States under this section.”.

14 **SEC. 403. PAYMENT OF DAMAGES AND RECOVERY OF**
15 **COSTS IN HEALTH CARE LAWSUITS.**

16 (a) AUTHORIZATION OF PAYMENT OF FUTURE DAM-
17 AGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.—In
18 any health care lawsuit, if an award of future damages,
19 without reduction to present value, equaling or exceeding
20 \$50,000 is made against a party with sufficient insurance
21 or other assets to fund a periodic payment of such a judg-
22 ment, the court shall, at the request of any party, enter
23 a judgment ordering that the future damages be paid by
24 periodic payments, in accordance with the Uniform Peri-
25 odic Payment of Judgments Act promulgated by the Na-

1 tional Conference of Commissioners on Uniform State
2 Laws.

3 (b) RECOVERY OF COSTS; PAYMENT OF AWARD.—

4 In any health care lawsuit, the court may supervise the
5 arrangements for payment of damages to protect against
6 conflicts of interest that may have the effect of reducing
7 the amount of damages awarded that are actually paid
8 to claimants. In particular, in any health care lawsuit in
9 which the attorney for a party claims a financial stake
10 in the outcome by virtue of a contingent fee, the court
11 shall have the power to restrict the payment of a claim-
12 ant's damage recovery to such attorney, and to redirect
13 such damages to the claimant based upon the interests
14 of justice and principles of equity.

15 (c) APPLICABILITY.—This section applies to all ac-
16 tions which have not been first set for trial or retrial be-
17 fore the effective date of this title.

18 (d) STATUTE OF LIMITATIONS.—Except in the case
19 of a State law that provides for a shorter period of time,
20 the time for the commencement of a health care lawsuit
21 shall be no more than 3 years after the date of manifesta-
22 tion of injury or 1 year after the claimant discovers, or
23 through the use of reasonable diligence should have discov-
24 ered, the injury, whichever occurs first. In no event shall
25 the time for commencement of a health care lawsuit exceed

1 3 years after the date of manifestation of injury unless
2 tolled for any of the following—

3 (1) upon proof of fraud;

4 (2) intentional concealment; or

5 (3) the presence of a foreign body, which has no
6 therapeutic or diagnostic purpose or effect, in the
7 person of the injured person.

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

19 (e) FAIR SHARE RULE.—In any health care lawsuit,
20 each party shall be liable for that party's several share
21 of any damages only and not for the share of any other
22 person. Each party shall be liable only for the amount of
23 damages allocated to such party in direct proportion to
24 such party's percentage of responsibility. Whenever a
25 judgment of liability is rendered as to any party, a sepa-

1 rate judgment shall be rendered against each such party
2 for the amount allocated to such party. For purposes of
3 this section, the trier of fact shall determine the propor-
4 tion of responsibility of each party for the claimant's
5 harm.

6 (f) APOLOGIES.—In any health care lawsuit, if a
7 claimant receives any expression of regret for any act per-
8 taining to conduct giving rise to the health care lawsuit,
9 such expression of regret, notwithstanding any applicable
10 rule of evidence may not be admitted into evidence in the
11 health care lawsuit.

12 **SEC. 404. DEFINITIONS.**

13 In this title:

14 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
15 TEM; ADR.—The term “alternative dispute resolution
16 system” or “ADR” means a system that provides
17 for the resolution of health care lawsuits in a man-
18 ner other than through a civil action brought in a
19 State or Federal court.

20 (2) CLAIMANT.—The term “claimant” means
21 any person who brings a health care lawsuit, includ-
22 ing a person who asserts or claims a right to legal
23 or equitable contribution, indemnity, or subrogation,
24 arising out of a health care liability claim or action,
25 and any person on whose behalf such a claim is as-

1 serted or such an action is brought, whether de-
2 ceased, incompetent, or a minor.

3 (3) FEDERAL TAX BENEFIT.—A claimant shall
4 be treated as receiving a Federal tax benefit with re-
5 spect to payment for items or services if—

6 (A) such payment is compensation by in-
7 surance—

8 (i) which constitutes medical care, and

9 (ii) with respect to the payment of
10 premiums for which the claimant, or the
11 employer of the claimant, was allowed an
12 exclusion from gross income, a deduction,
13 or a credit for Federal income tax pur-
14 poses,

15 (B) a deduction was allowed with respect
16 to such payment for Federal income tax pur-
17 poses, or

18 (C) such payment was from an Archer
19 MSA (as defined in section 220(d) of the Inter-
20 nal Revenue Code of 1986), a health savings
21 account (as defined in section 223(d) of such
22 Code), a flexible spending arrangement (as de-
23 fined in section 106(e)(2) of such Code), or a
24 health reimbursement arrangement which is
25 treated as employer-provided coverage under an

1 accident or health plan for purposes of section
2 106 of such Code.

3 (4) HEALTH CARE LAWSUIT.—The term
4 “health care lawsuit” means any health care liability
5 claim concerning the provision of health care goods
6 or services brought in a Federal court or in a State
7 court or pursuant to an alternative dispute resolu-
8 tion system, if such claim concerns items or services
9 for which coverage is provided under title XVIII,
10 XIX, or XXI of the Social Security Act or for which
11 the claimant receives a Federal tax benefit, against
12 a health care provider, a health care organization, or
13 the manufacturer, distributor, supplier, marketer,
14 promoter, or seller of a medical product, regardless
15 of the theory of liability on which the claim is based,
16 or the number of claimants, plaintiffs, defendants,
17 or other parties, or the number of claims or causes
18 of action, in which the claimant alleges a health care
19 liability claim. Such term does not include a claim
20 or action which is based on criminal liability; which
21 seeks civil fines or penalties paid to Federal Govern-
22 ment; or which is grounded in antitrust.

23 (5) HEALTH CARE LIABILITY ACTION.—The
24 term “health care liability action” means a civil ac-
25 tion brought in a State or Federal court or pursuant

1 to an alternative dispute resolution system, against
2 a health care provider, a health care organization, or
3 the manufacturer, distributor, supplier, marketer,
4 promoter, or seller of a medical product, regardless
5 of the theory of liability on which the claim is based,
6 or the number of plaintiffs, defendants, or other par-
7 ties, or the number of causes of action, in which the
8 claimant alleges a health care liability claim.

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

23 (7) HEALTH CARE ORGANIZATION.—The term
24 “health care organization” means any person or en-
25 tity which is obligated to provide or pay for health

1 benefits under any health plan, including any person
2 or entity acting under a contract or arrangement
3 with a health care organization to provide or admin-
4 ister any health benefit.

5 (8) HEALTH CARE PROVIDER.—The term
6 “health care provider” means any person or entity
7 required by State or Federal laws or regulations to
8 be licensed, registered, or certified to provide health
9 care services, and being either so licensed, reg-
10 istered, or certified, or exempted from such require-
11 ment by other statute or regulation.

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

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

1 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
2 Public Health Service Act (42 U.S.C. 262(a)), re-
3 spectively, including any component or raw material
4 used therein, but excluding health care services.

5 (11) MEDICAL TREATMENT.—The term “med-
6 ical treatment” means the provision of any goods or
7 services by a health care provider or by any indi-
8 vidual working under the supervision of a health
9 care provider, that relates to the diagnosis, preven-
10 tion, or treatment of any human disease or impair-
11 ment, or the assessment or care of the health of
12 human beings.

13 (12) RECOVERY.—The term “recovery” means
14 the net sum recovered after deducting any disburse-
15 ments or costs incurred in connection with prosecu-
16 tion or settlement of the claim, including all costs
17 paid or advanced by any person. Costs of health care
18 incurred by the plaintiff and the attorneys’ office
19 overhead costs or charges for legal services are not
20 deductible disbursements or costs for such purpose.

21 (13) STATE.—The term “State” means each of
22 the several States, the District of Columbia, the
23 Commonwealth of Puerto Rico, the Virgin Islands,
24 Guam, American Samoa, the Northern Mariana Is-
25 lands, the Trust Territory of the Pacific Islands, and

1 any other territory or possession of the United
2 States, or any political subdivision thereof.

3 **SEC. 405. EFFECT ON OTHER LAWS.**

4 (a) VACCINE INJURY.—

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

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

11 (B) any rule of law prescribed by this title
12 in conflict with a rule of law of such title XXI
13 shall not apply to such action.

14 (2) If there is an aspect of a civil action
15 brought for a vaccine-related injury or death to
16 which a Federal rule of law under title XXI of the
17 Public Health Service Act does not apply, then this
18 title or otherwise applicable law (as determined
19 under this title) will apply to such aspect of such ac-
20 tion.

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

1 **SEC. 406. APPLICABILITY; EFFECTIVE DATE.**

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

10 **TITLE V—WELLNESS AND**
11 **PREVENTION**

12 **SEC. 501. PROVIDING FINANCIAL INCENTIVES FOR TREAT-**
13 **MENT COMPLIANCE.**

14 (a) LIMITATION ON EXCEPTION FOR WELLNESS
15 PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

16 (1) EMPLOYEE RETIREMENT INCOME SECURITY
17 ACT OF 1974 AMENDMENT.—Section 702(b)(2) of the
18 Employee Retirement Income Security Act of 1974
19 (29 U.S.C. 1182(b)(2)) is amended by adding after
20 and below subparagraph (B) the following:

21 “In applying subparagraph (B), a group health plan
22 (or a health insurance issuer with respect to health
23 insurance coverage) may vary premiums and cost-
24 sharing by up to 50 percent of the value of the bene-
25 fits under the plan (or coverage) based on participa-

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

3 (2) PHSA AMENDMENT.—Section 2702(b)(2)
4 of the Public Health Service Act (42 U.S.C. 300gg–
5 1(b)(2)) is amended by adding after and below sub-
6 paragraph (B) the following:

7 “In applying subparagraph (B), a group health plan
8 (or a health insurance issuer with respect to health
9 insurance coverage) may vary premiums and cost-
10 sharing by up to 50 percent of the value of the bene-
11 fits under the plan (or coverage) based on participa-
12 tion (or lack of participation) in a standards-based
13 wellness program.”.

14 (3) IRC AMENDMENT.—Section 9802(b)(2) of
15 the Internal Revenue Code of 1986 is amended by
16 adding after and below subparagraph (B) the fol-
17 lowing:

18 “In applying subparagraph (B), a group health plan
19 may vary premiums and cost-sharing by up to 50
20 percent of the value of the benefits under the plan
21 based on participation (or lack of participation) in a
22 standards-based wellness program.”.

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

1 **TITLE VI—TRANSPARENCY AND**
2 **INSURANCE REFORM MEASURES**

3 **SEC. 601. RECEIPT AND RESPONSE TO REQUESTS FOR**
4 **CLAIM INFORMATION.**

5 (a) IN GENERAL.—Title XXVII of the Public Health
6 Service Act is amended by inserting after section 2713 the
7 following new section:

8 **“SEC. 2714. RECEIPT AND RESPONSE TO REQUESTS FOR**
9 **CLAIM INFORMATION.**

10 “(a) REQUIREMENT.—

11 “(1) IN GENERAL.—In the case of health insur-
12 ance coverage offered in connection with a group
13 health plan, not later than the 30th day after the
14 date a health insurance issuer receives a written re-
15 quest for a written report of claim information from
16 the plan, plan sponsor, or plan administrator, the
17 health insurance issuer shall provide the requesting
18 party the report, subject to the succeeding provisions
19 of this section.

20 “(2) EXCEPTION.—The health insurance issuer
21 is not obligated to provide a report under this sub-
22 section regarding a particular employer or group
23 health plan more than twice in any 12-month period
24 and is not obligated to provide such a report in the
25 case of an employer with fewer than 50 employees.

1 “(3) DEADLINE.—A plan, plan sponsor, or plan
2 administrator must request a report under this sub-
3 section before or on the second anniversary of the
4 date of termination of coverage under a group health
5 plan issued by the health insurance issuer.

6 “(b) FORM OF REPORT; INFORMATION TO BE IN-
7 CLUDED.—

8 “(1) IN GENERAL.—A health insurance issuer
9 shall provide the report of claim information under
10 subsection (a)—

11 “(A) in a written report;

12 “(B) through an electronic file transmitted
13 by secure electronic mail or a file transfer pro-
14 tocol site; or

15 “(C) by making the required information
16 available through a secure Web site or Web por-
17 tal accessible by the requesting plan, plan spon-
18 sor, or plan administrator.

19 “(2) INFORMATION TO BE INCLUDED.—A re-
20 port of claim information provided under subsection
21 (a) shall contain all information available to the
22 health insurance issuer that is responsive to the re-
23 quest made under such subsection, including, subject
24 to subsection (c), protected health information, for
25 the 36-month period preceding the date of the report

1 or the period specified by subparagraphs (D), (E),
2 and (F) of paragraph (3), if applicable, or for the
3 entire period of coverage, whichever period is short-
4 er.

5 “(3) REQUIRED INFORMATION.—Subject to
6 subsection (c), a report provided under subsection
7 (a) shall include the following:

8 “(A) Aggregate paid claims experience by
9 month, including claims experience for medical,
10 dental, and pharmacy benefits, as applicable.

11 “(B) Total premium paid by month.

12 “(C) Total number of covered employees
13 on a monthly basis by coverage tier, including
14 whether coverage was for—

15 “(i) an employee only;

16 “(ii) an employee with dependents
17 only;

18 “(iii) an employee with a spouse only;

19 or

20 “(iv) an employee with a spouse and
21 dependents.

22 “(D) The total dollar amount of claims
23 pending as of the date of the report.

24 “(E) A separate description and individual
25 claims report for any individual whose total

1 paid claims exceed \$15,000 during the 12-
2 month period preceding the date of the report,
3 including the following information related to
4 the claims for that individual—

5 “(i) a unique identifying number,
6 characteristic, or code for the individual;

7 “(ii) the amounts paid;

8 “(iii) dates of service; and

9 “(iv) applicable procedure codes and
10 diagnosis codes.

11 “(F) For claims that are not part of the
12 information described in a previous subpara-
13 graph, a statement describing precertification
14 requests for hospital stays of 5 days or longer
15 that were made during the 30-day period pre-
16 ceding the date of the report.

17 “(c) LIMITATIONS ON DISCLOSURE.—

18 “(1) IN GENERAL.—A health insurance issuer
19 may not disclose protected health information in a
20 report of claim information provided under this sec-
21 tion if the health insurance issuer is prohibited from
22 disclosing that information under another State or
23 Federal law that imposes more stringent privacy re-
24 strictions than those imposed under Federal law
25 under the HIPAA privacy regulations. To withhold

1 information in accordance with this subsection, the
2 health insurance issuer must—

3 “(A) notify the plan, plan sponsor, or plan
4 administrator requesting the report that infor-
5 mation is being withheld; and

6 “(B) provide to the plan, plan sponsor, or
7 plan administrator a list of categories of claim
8 information that the health insurance issuer has
9 determined are subject to the more stringent
10 privacy restrictions under another State or Fed-
11 eral law.

12 “(2) PROTECTION.—A plan sponsor is entitled
13 to receive protected health information under sub-
14 paragraph (E) and (F) of subsection (b)(3) and sub-
15 section (d) only after an appropriately authorized
16 representative of the plan sponsor makes to the
17 health insurance issuer a certification substantially
18 similar to the following certification: ‘I hereby certify
19 that the plan documents comply with the require-
20 ments of section 164.504(f)(2) of title 45, Code of
21 Federal Regulations, and that the plan sponsor will
22 safeguard and limit the use and disclosure of pro-
23 tected health information that the plan sponsor may
24 receive from the group health plan to perform the
25 plan administration functions.’.

1 “(3) RESULTS.—A plan sponsor that does not
2 provide the certification required by paragraph (2) is
3 not entitled to receive the protected health informa-
4 tion described by subparagraphs (E) and (F) of sub-
5 section (b)(3) and subsection (d), but is entitled to
6 receive a report of claim information that includes
7 the information described by subparagraphs (A)
8 through (D) of subsection (b)(3).

9 “(4) INFORMATION.—In the case of a request
10 made under subsection (a) after the date of termi-
11 nation of coverage, the report must contain all infor-
12 mation available to the health insurance issuer as of
13 the date of the report that is responsive to the re-
14 quest, including protected health information, and
15 including the information described by subsection
16 (b)(3), for the period described by subsection (b)(2)
17 preceding the date of termination of coverage or for
18 the entire policy period, whichever period is shorter.
19 Notwithstanding this subsection, the report may not
20 include the protected health information described
21 by subparagraphs (E) and (F) of subsection (b)(3)
22 unless a certification has been provided in accord-
23 ance with paragraph (2).

24 “(d) REQUEST FOR ADDITIONAL INFORMATION.—

1 “(1) REVIEW.—On receipt of the report re-
2 quired by subsection (a), the plan, plan sponsor, or
3 plan administrator may review the report and, not
4 later than the 10th day after the date the report is
5 received, may make a written request to the health
6 insurance issuer for additional information in ac-
7 cordance with this subsection for specified individ-
8 uals.

9 “(2) REQUEST.—With respect to a request for
10 additional information concerning specified individ-
11 uals for whom claims information has been provided
12 under subsection (b)(3)(E), the health insurance
13 issuer shall provide additional information on the
14 prognosis or recovery if available and, for individuals
15 in active case management, the most recent case
16 management information, including any future ex-
17 pected costs and treatment plan, that relate to the
18 claims for that individual.

19 “(3) RESPONSE.—The health insurance issuer
20 must respond to the request for additional informa-
21 tion under this subsection not later than the 15th
22 day after the date of such request unless the re-
23 questing plan, plan sponsor, or plan administrator
24 agrees to a request for additional time.

1 “(4) LIMITATION.—The health insurance issuer
2 is not required to produce the report described by
3 this subsection unless a certification has been pro-
4 vided in accordance with subsection (c)(2).

5 “(5) COMPLIANCE WITH SECTION DOES NOT
6 CREATE LIABILITY.—A health insurance issuer that
7 releases information, including protected health in-
8 formation, in accordance with this subsection has
9 not violated a standard of care and is not liable for
10 civil damages resulting from, and is not subject to
11 criminal prosecution for, releasing that information.

12 “(e) LIMITATION ON PREEMPTION.—Nothing in this
13 section is meant to limit States from enacting additional
14 laws in addition to the provisions of this section, but not
15 in lieu of such provisions.

16 “(f) DEFINITIONS.—In this section:

17 “(1) The terms ‘employer’, ‘plan administrator’,
18 and ‘plan sponsor’ have the meanings given such
19 terms in section 3 of the Employee Retirement In-
20 come Security Act of 1974.

21 “(2) The term ‘HIPAA privacy regulations’ has
22 the meaning given such term in section 1180(b)(3)
23 of the Social Security Act.

1 “(3) The term ‘protected health information’
2 has the meaning given such term under the HIPAA
3 privacy regulations.”.

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

7 **TITLE VII—QUALITY**

8 **SEC. 701. PROHIBITION ON CERTAIN USES OF DATA OB-** 9 **TAINED FROM COMPARATIVE EFFECTIVE-** 10 **NESS RESEARCH OR FROM PATIENT-CEN-** 11 **TERED OUTCOMES RESEARCH; ACCOUNTING** 12 **FOR PERSONALIZED MEDICINE AND DIF-** 13 **FERENCES IN PATIENT TREATMENT RE-** 14 **SPONSE.**

15 (a) IN GENERAL.—Notwithstanding any other provi-
16 sion of law, the Secretary of Health and Human Serv-
17 ices—

18 (1) shall not use data obtained from the con-
19 duct of comparative effectiveness research or pa-
20 tient-centered outcomes research, including such re-
21 search that is conducted or supported using funds
22 appropriated under the American Recovery and Re-
23 investment Act of 2009 (Public Law 111–5), to deny
24 coverage of an item or service under a Federal
25 health care program (as defined in section 1128B(f))

1 of the Social Security Act (42 U.S.C. 1320a–7b(f));
2 and

3 (2) shall ensure that comparative effectiveness
4 research and patient-centered outcomes research
5 conducted or supported by the Federal Government
6 accounts for factors contributing to differences in
7 the treatment response and treatment preferences of
8 patients, including patient-reported outcomes,
9 genomics and personalized medicine, the unique
10 needs of health disparity populations, and indirect
11 patient benefits.

12 (b) CONSULTATION AND APPROVAL REQUIRED.—
13 Nothing the Federal Coordinating Council for Compara-
14 tive Effectiveness Research finds can be released in final
15 form until after consultation with and approved by rel-
16 evant physician specialty organizations.

17 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed as affecting the authority of the
19 Commissioner of Food and Drugs under the Federal
20 Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.)
21 or the Public Health Service Act (42 U.S.C. 201 et seq.).

22 **SEC. 702. ESTABLISHMENT OF PERFORMANCE-BASED**
23 **QUALITY MEASURES.**

24 Not later than January 1, 2016, the Secretary of
25 Health and Human Services shall submit to Congress a

1 proposal for a formalized process for the development of
2 performance-based quality measures that could be applied
3 to physicians' services under the Medicare program under
4 title XVIII of the Social Security Act (42 U.S.C. 1395
5 et seq.). Such proposal shall be in concert and agreement
6 with the Physician Consortium for Performance Improve-
7 ment and shall only utilize measures agreed upon by each
8 physician specialty organization.

9 **TITLE VIII—STATE**
10 **TRANSPARENCY PLAN PORTAL**

11 **SEC. 801. PROVIDING INFORMATION ON HEALTH COV-**
12 **ERAGE OPTIONS AND HEALTH CARE PRO-**
13 **VIDERS.**

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

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

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

25 (b) PROHIBITIONS.—

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

5 (2) CONFLICTS OF INTEREST.—

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

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

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

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

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

21 (ii) the plan portal.

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

25 (1) utilizing the plan portal for any purpose; or

1 (2) marketing or offering health insurance
2 products.

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

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

11 **TITLE IX—PATIENT FREEDOM**
12 **OF CHOICE**

13 **SEC. 901. GUARANTEEING FREEDOM OF CHOICE AND CON-**
14 **TRACTING FOR PATIENTS UNDER MEDICARE.**

15 (a) IN GENERAL.—Section 1802 of the Social Secu-
16 rity Act (42 U.S.C. 1395a) is amended to read as follows:

17 “FREEDOM OF CHOICE AND CONTRACTING BY PATIENT
18 GUARANTEED

19 “SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any
20 individual entitled to insurance benefits under this title
21 may obtain health services from any institution, agency,
22 or person qualified to participate under this title if such
23 institution, agency, or person undertakes to provide that
24 individual such services.

25 “(b) FREEDOM TO CONTRACT BY MEDICARE BENE-
26 FICIARIES.—

1 “(1) IN GENERAL.—Subject to the provisions of
2 this subsection, nothing in this title shall prohibit a
3 Medicare beneficiary from entering into a contract
4 with an eligible professional (whether or not the pro-
5 fessional is a participating or non-participating phy-
6 sician or practitioner) for any item or service cov-
7 ered under this title.

8 “(2) SUBMISSION OF CLAIMS.—Any Medicare
9 beneficiary that enters into a contract under this
10 section with an eligible professional shall be per-
11 mitted to submit a claim for payment under this
12 title for services furnished by such professional, and
13 such payment shall be made in the amount that
14 would otherwise apply to such professional under
15 this title except that where such professional is con-
16 sidered to be non-participating, payment shall be
17 paid as if the professional were participating. Pay-
18 ment made under this title for any item or service
19 provided under the contract shall not render the pro-
20 fessional a participating or non-participating physi-
21 cian or practitioner, and as such, requirements of
22 this title that may otherwise apply to a participating
23 or non-participating physician or practitioner would
24 not apply with respect to any items or services fur-
25 nished under the contract.

1 “(3) BENEFICIARY PROTECTIONS.—

2 “(A) IN GENERAL.—Paragraph (1) shall
3 not apply to any contract unless—

4 “(i) the contract is in writing, is
5 signed by the Medicare beneficiary and the
6 eligible professional, and establishes all
7 terms of the contract (including specific
8 payment for items and services covered by
9 the contract) before any item or service is
10 provided pursuant to the contract, and the
11 beneficiary shall be held harmless for any
12 subsequent payment charged for an item
13 or service in excess of the amount estab-
14 lished under the contract during the period
15 the contract is in effect;

16 “(ii) the contract contains the items
17 described in subparagraph (B); and

18 “(iii) the contract is not entered into
19 at a time when the Medicare beneficiary is
20 facing an emergency medical condition or
21 urgent health care situation.

22 “(B) ITEMS REQUIRED TO BE INCLUDED
23 IN CONTRACT.—Any contract to provide items
24 and services to which paragraph (1) applies

1 shall clearly indicate to the Medicare beneficiary
2 that by signing such contract the beneficiary—

3 “(i) agrees to be responsible for pay-
4 ment to such eligible professional for such
5 items or services under the terms of and
6 amounts established under the contract;

7 “(ii) agrees to be responsible for sub-
8 mitting claims under this title to the Sec-
9 retary, and to any other supplemental in-
10 surance plan that may provide supple-
11 mental insurance, for such items or serv-
12 ices furnished under the contract if such
13 items or services are covered by this title,
14 unless otherwise provided in the contract
15 under subparagraph (C)(i); and

16 “(iii) acknowledges that no limits or
17 other payment incentives that may other-
18 wise apply under this title (such as the
19 limits under subsection (g) of section 1848
20 or incentives under subsections (a)(5), (m),
21 (q), and (p) of such section) shall apply to
22 amounts that may be charged, or paid to
23 a beneficiary for, such items or services.

24 Such contract shall also clearly indicate whether
25 the eligible professional is excluded from par-

1 ticipation under the Medicare program under
2 section 1128.

3 “(C) BENEFICIARY ELECTIONS UNDER
4 THE CONTRACT.—Any Medicare beneficiary
5 that enters into a contract under this section
6 may elect to negotiate, as a term of the con-
7 tract, a provision under which—

8 “(i) the eligible professional shall file
9 claims on behalf of the beneficiary with the
10 Secretary and any supplemental insurance
11 plan for items or services furnished under
12 the contract if such items or services are
13 covered under this title or under the plan;
14 and

15 “(ii) the beneficiary assigns payment
16 to the eligible professional for any claims
17 filed by, or on behalf of, the beneficiary
18 with the Secretary and any supplemental
19 insurance plan for items or services fur-
20 nished under the contract.

21 “(D) EXCLUSION OF DUAL ELIGIBLE INDI-
22 VIDUALS.—Paragraph (1) shall not apply to
23 any contract if a beneficiary who is eligible for
24 medical assistance under title XIX is a party to
25 the contract.

1 “(4) LIMITATION ON ACTUAL CHARGE AND
2 CLAIM SUBMISSION REQUIREMENT NOT APPLICA-
3 BLE.—Section 1848(g) shall not apply with respect
4 to any item or service provided to a Medicare bene-
5 ficiary under a contract described in paragraph (1).

6 “(5) CONSTRUCTION.—Nothing in this section
7 shall be construed—

8 “(A) to prohibit any eligible professional
9 from maintaining an election and acting as a
10 participating or non-participating physician or
11 practitioner with respect to any patient not cov-
12 ered under a contract established under this
13 section; and

14 “(B) as changing the items and services
15 for which an eligible professional may bill under
16 this title.

17 “(6) DEFINITIONS.—In this subsection:

18 “(A) MEDICARE BENEFICIARY.—The term
19 ‘Medicare beneficiary’ means an individual who
20 is entitled to benefits under part A or enrolled
21 under part B.

22 “(B) ELIGIBLE PROFESSIONAL.—The term
23 ‘eligible professional’ has the meaning given
24 such term in section 1848(k)(3)(B).

1 “(C) EMERGENCY MEDICAL CONDITION.—
2 The term ‘emergency medical condition’ means
3 a medical condition manifesting itself by acute
4 symptoms of sufficient severity (including se-
5 vere pain) such that a prudent layperson, with
6 an average knowledge of health and medicine,
7 could reasonably expect the absence of imme-
8 diate medical attention to result in—

9 “(i) serious jeopardy to the health of
10 the individual or, in the case of a pregnant
11 woman, the health of the woman or her
12 unborn child;

13 “(ii) serious impairment to bodily
14 functions; or

15 “(iii) serious dysfunction of any bodily
16 organ or part.

17 “(D) URGENT HEALTH CARE SITUA-
18 TION.—The term ‘urgent health care situation’
19 means services furnished to an individual who
20 requires services to be furnished within 12
21 hours in order to avoid the likely onset of an
22 emergency medical condition.”.

1 **SEC. 902. PREEMPTION OF STATE LAWS LIMITING**
2 **CHARGES FOR ELIGIBLE PROFESSIONAL**
3 **SERVICES.**

4 (a) **IN GENERAL.**—No State may impose a limit on
5 the amount of charges for services, furnished by an eligible
6 professional (as defined in subsection (k)(3)(B) of section
7 1848 of the Social Security Act, 42 U.S.C. 1395w-4), for
8 which payment is made under such section, and any such
9 limit is hereby preempted.

10 (b) **STATE.**—In this section, the term “State” in-
11 cludes the District of Columbia, Puerto Rico, the Virgin
12 Islands, Guam, and American Samoa.

13 **SEC. 903. HEALTH CARE PROVIDER LICENSURE CANNOT BE**
14 **CONDITIONED ON PARTICIPATION IN A**
15 **HEALTH PLAN.**

16 (a) **IN GENERAL.**—The Secretary of Health and
17 Human Services and any State (as a condition of receiving
18 Federal financial participation under title XIX of the So-
19 cial Security Act) may not require any health care pro-
20 vider to participate in any health plan as a condition of
21 licensure of the provider in any State.

22 (b) **DEFINITIONS.**—In this section:

23 (1) **HEALTH PLAN.**—The term “health plan”
24 has the meaning given such term in section 1171(5)
25 of the Social Security Act (42 U.S.C. 1320d(5)).

1 (2) HEALTH CARE PROVIDER.—The term
 2 “health care provider” means any person or entity
 3 that is required by State or Federal laws or regula-
 4 tions to be licensed, registered, or certified to pro-
 5 vide health care services and is so licensed, reg-
 6 istered, or certified, or exempted from such require-
 7 ment by other statute or regulation.

8 (3) STATE.—The term “State” has the mean-
 9 ing given such term for purposes of title XIX of the
 10 Social Security Act.

11 **SEC. 904. BAD DEBT DEDUCTION FOR DOCTORS TO PAR-**
 12 **TIALLY OFFSET THE COST OF PROVIDING UN-**
 13 **COMPENSATED CARE REQUIRED TO BE PRO-**
 14 **VIDED UNDER AMENDMENTS MADE BY THE**
 15 **EMERGENCY MEDICAL TREATMENT AND**
 16 **LABOR ACT.**

17 (a) IN GENERAL.—Section 166 of the Internal Rev-
 18 enue Code of 1986 (relating to bad debts) is amended by
 19 redesignating subsection (f) as subsection (g) and by in-
 20 serting after subsection (e) the following new subsection:

21 “(f) BAD DEBT TREATMENT FOR DOCTORS TO PAR-
 22 TIALLY OFFSET COST OF PROVIDING UNCOMPENSATED
 23 CARE REQUIRED TO BE PROVIDED.—

24 “(1) AMOUNT OF DEDUCTION.—

1 “(A) IN GENERAL.—For purposes of sub-
2 section (a), the basis for determining the
3 amount of any deduction for an eligible
4 EMTALA debt shall be treated as being equal
5 to the Medicare payment amount.

6 “(B) MEDICARE PAYMENT AMOUNT.—For
7 purposes of subparagraph (A), the Medicare
8 payment amount with respect to an eligible
9 EMTALA debt is the fee schedule amount es-
10 tablished under section 1848 of the Social Secu-
11 rity Act for the physicians’ service (to which
12 such debt relates) as if the service were pro-
13 vided to an individual enrolled under part B of
14 title XVIII of such Act.

15 “(2) ELIGIBLE EMTALA DEBT.—For purposes
16 of this section, the term ‘eligible EMTALA debt’
17 means any debt if—

18 “(A) such debt arose as a result of physi-
19 cians’ services—

20 “(i) which were performed in an
21 EMTALA hospital by a board-certified
22 physician (whether as part of medical
23 screening or necessary stabilizing treat-
24 ment and whether as an emergency depart-

1 ment physician, as an on-call physician, or
2 otherwise), and

3 “(ii) which were required to be pro-
4 vided under section 1867 of the Social Se-
5 curity Act (42 U.S.C. 1395dd), and

6 “(B) such debt is owed—

7 “(i) to such physician, or

8 “(ii) to an entity if—

9 “(I) such entity is a corporation
10 and the sole shareholder of such cor-
11 poration is such physician, or

12 “(II) such entity is a partnership
13 and any deduction under this sub-
14 section with respect to such debt is al-
15 located to such physician or to an en-
16 tity described in subclause (I).

17 “(3) BOARD-CERTIFIED PHYSICIAN.—For pur-
18 poses of this subsection, the term ‘board-certified
19 physician’ means any physician (as defined in sec-
20 tion 1861(r) of the Social Security Act (42 U.S.C.
21 1395x(r))) who is certified by the American Board
22 of Emergency Medicine or other appropriate medical
23 specialty board for the specialty in which the physi-
24 cian practices, or who meets comparable require-
25 ments, as identified by the Secretary of the Treasury

1 in consultation with Secretary of Health and Human
2 Services.

3 “(4) OTHER DEFINITIONS.—For purposes of
4 this subsection—

5 “(A) EMTALA HOSPITAL.—The term
6 ‘EMTALA hospital’ means any hospital having
7 a hospital emergency department which is re-
8 quired to comply with section 1867 of the So-
9 cial Security Act (42 U.S.C. 1395dd) (relating
10 to examination and treatment for emergency
11 medical conditions and women in labor).

12 “(B) PHYSICIANS’ SERVICES.—The term
13 ‘physicians’ services’ has the meaning given
14 such term in section 1861(q) of the Social Se-
15 curity Act (42 U.S.C. 1395x(q)).”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to debts arising from services per-
18 formed in taxable years beginning after the date of the
19 enactment of this Act.

20 **SEC. 905. RIGHT OF CONTRACT WITH HEALTH CARE PRO-**
21 **VIDERS.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services shall not preclude an enrollee, partici-
24 pant, or beneficiary in a health benefits plan from entering

1 into any contract or arrangement for health care with any
2 health care provider.

3 (b) HEALTH BENEFITS PLAN DEFINED.—

4 (1) IN GENERAL.—In this section, subject to
5 paragraph (2), the term “health benefits plan”
6 means any of the following:

7 (A) Group health plan (as defined in sec-
8 tion 2791 of the Public Health Service Act).

9 (B) Health insurance coverage (as defined
10 in section 2791 of such Act).

11 (C) A health benefits plan under chapter
12 89 of title 5, United States Code.

13 (2) EXCLUSION OF MEDICAID AND TRICARE.—

14 Such term does not include a health plan partici-
15 pating in—

16 (A) the Medicaid program under title XIX
17 of the Social Security Act; or

18 (B) the TRICARE program under chapter
19 55 of title 10, United States Code.

20 (c) HEALTH CARE PROVIDER DEFINED.—In this
21 section, the term “health care provider” means—

22 (1) a physician, as defined in paragraphs (1),
23 (2), (3), and (4) of section 1861(r) of the Social Se-
24 curity Act (42 U.S.C. 1395x(r)); and

1 (2) a health care practitioner described in sec-
2 tion 1842(b)(18)(C) of such Act (42 U.S.C.
3 1395u(b)(18)(C)).

4 **TITLE X—QUALITY HEALTH**
5 **CARE COALITION**

6 **SEC. 1001. QUALITY HEALTH CARE COALITION.**

7 (a) APPLICATION OF THE FEDERAL ANTITRUST
8 LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING
9 WITH HEALTH PLANS.—

10 (1) IN GENERAL.—Any health care profes-
11 sionals who are engaged in negotiations with a
12 health plan regarding the terms of any contract
13 under which the professionals provide health care
14 items or services for which benefits are provided
15 under such plan shall, in connection with such nego-
16 tiations, be exempt from the Federal antitrust laws.

17 (2) LIMITATION.—

18 (A) NO NEW RIGHT FOR COLLECTIVE CES-
19 SATION OF SERVICE.—The exemption provided
20 in paragraph (1) shall not confer any new right
21 to participate in any collective cessation of serv-
22 ice to patients not already permitted by existing
23 law.

24 (B) NO CHANGE IN NATIONAL LABOR RE-
25 LATIONS ACT.—This section applies only to

1 health care professionals excluded from the Na-
2 tional Labor Relations Act. Nothing in this sec-
3 tion shall be construed as changing or amend-
4 ing any provision of the National Labor Rela-
5 tions Act, or as affecting the status of any
6 group of persons under that Act.

7 (3) NO APPLICATION TO FEDERAL PRO-
8 GRAMS.—Nothing in this section shall apply to nego-
9 tiations between health care professionals and health
10 plans pertaining to benefits provided under any of
11 the following:

12 (A) The Medicare Program under title
13 XVIII of the Social Security Act (42 U.S.C.
14 1395 et seq.).

15 (B) The Medicaid program under title XIX
16 of the Social Security Act (42 U.S.C. 1396 et
17 seq.).

18 (C) The SCHIP program under title XXI
19 of the Social Security Act (42 U.S.C. 1397aa et
20 seq.).

21 (D) Chapter 55 of title 10, United States
22 Code (relating to medical and dental care for
23 members of the uniformed services).

24 (E) Chapter 17 of title 38, United States
25 Code (relating to Veterans' medical care).

1 (F) Chapter 89 of title 5, United States
2 Code (relating to the Federal employees' health
3 benefits program).

4 (G) The Indian Health Care Improvement
5 Act (25 U.S.C. 1601 et seq.).

6 (b) DEFINITIONS.—In this section, the following defi-
7 nitions shall apply:

8 (1) ANTITRUST LAWS.—The term “antitrust
9 laws”—

10 (A) has the meaning given it in subsection
11 (a) of the first section of the Clayton Act (15
12 U.S.C. 12(a)), except that such term includes
13 section 5 of the Federal Trade Commission Act
14 (15 U.S.C. 45) to the extent such section ap-
15 plies to unfair methods of competition; and

16 (B) includes any State law similar to the
17 laws referred to in subparagraph (A).

18 (2) GROUP HEALTH PLAN.—The term “group
19 health plan” means an employee welfare benefit plan
20 to the extent that the plan provides medical care (in-
21 cluding items and services paid for as medical care)
22 to employees or their dependents (as defined under
23 the terms of the plan) directly or through insurance,
24 reimbursement, or otherwise.

1 (3) GROUP HEALTH PLAN, HEALTH INSURANCE
2 ISSUER.—The terms “group health plan” and
3 “health insurance issuer” include a third-party ad-
4 ministrators or other person acting for or on behalf
5 of such plan or issuer.

6 (4) HEALTH CARE SERVICES.—The term
7 “health care services” means any services for which
8 payment may be made under a health plan, includ-
9 ing services related to the delivery or administration
10 of such services.

11 (5) HEALTH CARE PROFESSIONAL.—The term
12 “health care professional” means any individual or
13 entity that provides health care items or services,
14 treatment, assistance with activities of daily living,
15 or medications to patients and who, to the extent re-
16 quired by State or Federal law, possesses specialized
17 training that confers expertise in the provision of
18 such items or services, treatment, assistance, or
19 medications.

20 (6) HEALTH INSURANCE COVERAGE.—The term
21 “health insurance coverage” means benefits con-
22 sisting of medical care (provided directly, through
23 insurance or reimbursement, or otherwise and in-
24 cluding items and services paid for as medical care)
25 under any hospital or medical service policy or cer-

1 tificate, hospital or medical service plan contract, or
2 health maintenance organization contract offered by
3 a health insurance issuer.

4 (7) HEALTH INSURANCE ISSUER.—The term
5 “health insurance issuer” means an insurance com-
6 pany, insurance service, or insurance organization
7 (including a health maintenance organization) that
8 is licensed to engage in the business of insurance in
9 a State and that is subject to State law regulating
10 insurance. Such term does not include a group
11 health plan.

12 (8) HEALTH MAINTENANCE ORGANIZATION.—
13 The term “health maintenance organization”
14 means—

15 (A) a federally qualified health mainte-
16 nance organization (as defined in section
17 1301(a) of the Public Health Service Act (42
18 U.S.C. 300e(a)));

19 (B) an organization recognized under State
20 law as a health maintenance organization; or

21 (C) a similar organization regulated under
22 State law for solvency in the same manner and
23 to the same extent as such a health mainte-
24 nance organization.

1 (9) HEALTH PLAN.—The term “health plan”
2 means a group health plan or a health insurance
3 issuer that is offering health insurance coverage.

4 (10) MEDICAL CARE.—The term “medical
5 care” means amounts paid for—

6 (A) the diagnosis, cure, mitigation, treat-
7 ment, or prevention of disease, or amounts paid
8 for the purpose of affecting any structure or
9 function of the body; and

10 (B) transportation primarily for and essen-
11 tial to receiving items and services referred to
12 in subparagraph (A).

13 (11) PERSON.—The term “person” includes a
14 State or unit of local government.

15 (12) STATE.—The term “State” includes the
16 several States, the District of Columbia, Puerto
17 Rico, the Virgin Islands of the United States, Guam,
18 American Samoa, and the Commonwealth of the
19 Northern Mariana Islands.

20 (c) EFFECTIVE DATE.—This section shall take effect
21 on the date of the enactment of this Act and shall not
22 apply with respect to conduct occurring before such date.

○