

115TH CONGRESS
1ST SESSION

H. R. 277

To repeal the Patient Protection and Affordable Care Act and related reconciliation provisions, to promote patient-centered health care, to provide for the creation of a safe harbor for defendants in medical malpractice actions who demonstrate adherence to clinical practice guidelines, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 4, 2017

Mr. ROE of Tennessee (for himself, Mr. WALKER, Mr. ROKITA, Mr. GOSAR, Mr. FLORES, Mr. BARR, Mr. CARTER of Georgia, Mr. AUSTIN SCOTT of Georgia, Mr. DUNCAN of Tennessee, Mr. HILL, Mr. CHABOT, Mrs. BLACKBURN, Mr. ROUZER, Mr. CULBERSON, Mrs. HARTZLER, Mr. BABIN, Mr. BUCSHON, and Mr. SCALISE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Budget, Ways and Means, Education and the Workforce, the Judiciary, Natural Resources, House Administration, Rules, Appropriations, and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To repeal the Patient Protection and Affordable Care Act and related reconciliation provisions, to promote patient-centered health care, to provide for the creation of a safe harbor for defendants in medical malpractice actions who demonstrate adherence to clinical practice guidelines, 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 “American Health Care Reform Act of 2017”.

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

Sec. 1. Short title; table of contents.

TITLE I—REPEAL OF OBAMACARE

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

Sec. 102. Budgetary effects.

TITLE II—INCREASING ACCESS TO PORTABLE, AFFORDABLE
 HEALTH INSURANCE

Sec. 200. Amendment of 1986 Code.

Subtitle A—Standard Deduction for Health Insurance

Sec. 201. Standard deduction for health insurance.

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

Sec. 203. Exclusion of standard deduction for health insurance from employ-
 ment taxes.

Sec. 204. Information reporting.

Sec. 205. Election to disregard inclusion of contributions by employer to acci-
 dent or health plan.

Subtitle B—Enhancement of Health Savings Accounts

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

Sec. 222. Provisions relating to Medicare.

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

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

Sec. 225. Individuals eligible for TRICARE coverage.

Sec. 226. FSA and HRA interaction with HSAs.

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

Sec. 228. Special rule for certain medical expenses incurred before establish-
 ment of account.

Sec. 229. Preventive care prescription drug clarification.

Sec. 230. Equivalent bankruptcy protections for health savings accounts as re-
 tirement funds.

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

- Sec. 232. Reauthorization of Medicaid health opportunity accounts.
- Sec. 233. Members of health care sharing ministries eligible to establish health savings accounts.
- Sec. 234. High deductible health plans renamed HSA qualified plans.
- Sec. 235. Treatment of direct primary care service arrangements.
- Sec. 236. Certain exercise equipment and physical fitness programs treated as medical care.
- Sec. 237. Certain nutritional and dietary supplements to be treated as medical care.
- Sec. 238. Certain provider fees to be treated as medical care.
- Sec. 239. Increase the maximum contribution limit to an HSA to match deductible and out-of-pocket expense limitation.
- Sec. 240. Child health savings account.
- Sec. 241. Allowing minimum distributions from tax-deferred retirement accounts to be deposited into HSAs.
- Sec. 242. Distributions for abortion expenses from health savings accounts included in gross income.

Subtitle C—Enhanced Wellness Incentives

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

TITLE III—IMPROVING ACCESS TO INSURANCE FOR VULNERABLE AMERICANS

Subtitle A—Eliminating Barriers to Insurance Coverage

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

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

- Sec. 311. Improvement of high-risk pools.

TITLE IV—ENCOURAGING A MORE COMPETITIVE HEALTH CARE MARKET

Subtitle A—Expanding Patient Choice

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

Subtitle B—McCarran-Ferguson Reform

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

Subtitle C—Medicare Price Transparency

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

Subtitle D—State Transparency Portals

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

Subtitle E—Protecting the Doctor-Patient Relationship

- Sec. 441. Rule of construction.

Sec. 442. Repeal of Federal Coordinating Council for Comparative Effectiveness Research.

Subtitle F—Establishing Association Health Plans

Sec. 451. Rules governing association health plans.
 Sec. 452. Clarification of treatment of single employer arrangements.
 Sec. 453. Enforcement provisions relating to association health plans.
 Sec. 454. Cooperation between Federal and State authorities.
 Sec. 455. Effective date and transitional and other rules.

Subtitle G—Greater Choice for Veterans

Sec. 461. Removing barriers to health care choice for Category 1 veterans and medal of honor recipients.

TITLE V—REFORMING MEDICAL LIABILITY LAW

Sec. 501. Requirements for selection of clinical practice guidelines.
 Sec. 502. Development.
 Sec. 503. No liability for guideline producers.
 Sec. 504. Internet publication of guidelines.
 Sec. 505. State flexibility and protection of States' rights.
 Sec. 506. Federal cause of action.
 Sec. 507. Right of removal.
 Sec. 508. Mandatory review by independent medical panel.
 Sec. 509. Definitions.

TITLE VI—OTHER PROVISIONS

Sec. 601. Respecting human life.
 Sec. 602. Offsets.

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

6 (a) PPACA.—Effective on January 1, 2018, the Pa-
 7 tient Protection and Affordable Care Act (Public Law
 8 111–148) is repealed, and the provisions of law amended
 9 or repealed by such Act are restored or revived as if such
 10 Act had not been enacted.

1 (b) HEALTH CARE-RELATED PROVISIONS IN THE
2 HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
3 2010.—Effective on January 1, 2018, title I and subtitle
4 B of title II of the Health Care and Education Reconcili-
5 ation Act of 2010 (Public Law 111–152) are repealed, and
6 the provisions of law amended or repealed by such title
7 or subtitle, respectively, are restored or revived as if such
8 title and subtitle had not been enacted.

9 **SEC. 102. BUDGETARY EFFECTS.**

10 The budgetary effects of this Act shall not be entered
11 on either PAYGO scorecard maintained pursuant to sec-
12 tion 4(d) of the Statutory Pay-As-You-Go Act of 2010.

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

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

17 Except as otherwise expressly provided, whenever in
18 this title an amendment or repeal is expressed in terms
19 of an amendment to, or repeal of, a section or other provi-
20 sion, the reference shall be considered to be made to a
21 section or other provision of the Internal Revenue Code
22 of 1986.

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

3 **SEC. 201. STANDARD DEDUCTION FOR HEALTH INSUR-**
 4 **ANCE.**

5 (a) IN GENERAL.—Part VII of subchapter B of chap-
 6 ter 1 is amended by redesignating section 224 as section
 7 225 and by inserting after section 223 the following new
 8 section:

9 **“SEC. 224. STANDARD DEDUCTION FOR HEALTH INSUR-**
 10 **ANCE.**

11 “(a) DEDUCTION ALLOWED.—In the case of an indi-
 12 vidual, there shall be allowed as a deduction to the tax-
 13 payer for the taxable year the standard deduction for
 14 health insurance.

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

17 “(1) IN GENERAL.—The term ‘standard deduc-
 18 tion for health insurance’ means the sum of the
 19 monthly limitations for months during the taxable
 20 year.

21 “(2) MONTHLY LIMITATION.—

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

24 “(i) \$20,500, in the case of a tax-
 25 payer who is allowed a deduction under

1 section 151 for more than one individual
2 who for such month is an eligible indi-
3 vidual, and

4 “(ii) \$7,500, in the case of a taxpayer
5 who is allowed a deduction under section
6 151 for only one individual who for such
7 month is an eligible individual.

8 “(B) COST-OF-LIVING ADJUSTMENT.—

9 “(i) IN GENERAL.—In the case of tax-
10 able years beginning in calendar years
11 after the first calendar year to which this
12 section applies, the dollar amounts under
13 subparagraph (A) shall be increased by an
14 amount equal to—

15 “(I) such dollar amount, multi-
16 plied by

17 “(II) the cost-of-living adjust-
18 ment determined under section 1(f)(3)
19 for the calendar year in which such
20 taxable year begins, determined by
21 substituting ‘the calendar year pre-
22 ceding the first calendar year to which
23 section 224 applies’ for ‘calendar year
24 1992’ in subparagraph (B) thereof.

1 “(ii) ROUNDING.—If any increase
2 under clause (i) is not a multiple of \$50,
3 such increase shall be rounded to the near-
4 est multiple of \$50.

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

10 “(c) LIMITATIONS AND SPECIAL RULES RELATING
11 TO STANDARD DEDUCTION.—For purposes of this sec-
12 tion—

13 “(1) SPECIAL RULE FOR MARRIED INDIVIDUALS
14 FILING SEPARATELY.—In the case of a married indi-
15 vidual who files a separate return for the taxable
16 year, the deduction allowed under subsection (a)
17 shall be equal to one-half of the amount which would
18 otherwise be determined under subsection (a) if such
19 individual filed a joint return for the taxable year.

20 “(2) DENIAL OF DEDUCTION TO DEPEND-
21 ENTS.—No deduction shall be allowed under this
22 section to any individual with respect to whom a de-
23 duction under section 151 is allowable to another
24 taxpayer for a taxable year beginning in the cal-

1 endar year in which such individual's taxable year
2 begins.

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

5 “(A) DENIAL OF DEDUCTION IF HEALTH
6 INSURANCE COSTS CREDIT ALLOWED.—No de-
7 duction shall be allowed under this section to
8 any taxpayer if a credit is allowed to the tax-
9 payer under section 35 for the taxable year.

10 “(B) REDUCTION FOR INSURANCE PUR-
11 CHASED WITH MSA OR HSA FUNDS.—The
12 amount allowed as a deduction under subsection
13 (a) for the taxable year shall be reduced by the
14 aggregate amount—

15 “(i) paid during the taxable year from
16 an Archer MSA to which section
17 220(d)(2)(B)(ii) (other than subclause (II)
18 thereof) applies, and

19 “(ii) paid during the taxable year
20 from a health savings account to which
21 section 223(d)(2)(C) (other than clause (ii)
22 thereof) applies.

23 “(4) SPECIAL RULE FOR DIVORCED PARENTS,
24 ETC.—Notwithstanding subsection (b)(1), an indi-
25 vidual who is a child may be taken into account on

1 the return of the parent other than the parent for
2 whom a deduction with respect to the child is al-
3 lowed under section 151 for a taxable year beginning
4 in a calendar year if—

5 “(A) the parent for whom the deduction
6 under section 151 is allowed for a taxable year
7 beginning in such calendar year signs a written
8 declaration (in such manner and form as the
9 Secretary may by regulations prescribe) that
10 such parent will not claim the deduction allow-
11 able under this section with respect to the child
12 for taxable years beginning in such calendar
13 year, and

14 “(B) the parent for whom the deduction
15 under section 151 is not allowed attaches such
16 written declaration to the parent’s return for
17 the taxable year beginning in such calendar
18 year.

19 “(d) OTHER DEFINITIONS.—For purposes of this
20 section—

21 “(1) ELIGIBLE INDIVIDUAL.—

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

1 “(B) COVERAGE UNDER MEDICARE, MED-
2 ICAID, SCHIP, TRICARE, AND GRANDFATHERED
3 EMPLOYER COVERAGE.—The term ‘eligible indi-
4 vidual’ shall not include any individual who for
5 any month is—

6 “(i) entitled to benefits under part A
7 of title XVIII of the Social Security Act or
8 enrolled under part B of such title,

9 “(ii) enrolled in the program under
10 title XIX or XXI of such Act (other than
11 under section 1928 of such Act),

12 “(iii) receiving benefits (other than
13 under continuation coverage under section
14 4980B) which constitute medical care from
15 an employer—

16 “(I) from whom such individual
17 is separated from service at the time
18 of receipt of such benefits, and

19 “(II) after such separation, if
20 such benefits began before January 1,
21 2018, unless such individual is also
22 covered by a qualified health plan as
23 of the 1st day of such month, or

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

1 “(C) IDENTIFICATION REQUIREMENTS.—

2 The term ‘eligible individual’ shall not include
3 any individual for any month unless the policy
4 number associated with coverage under the
5 qualified health plan and the TIN of each eligi-
6 ble individual covered under such coverage for
7 such month is included on the return for the
8 taxable year in which such month occurs.

9 “(2) QUALIFIED HEALTH PLAN.—

10 “(A) IN GENERAL.—The term ‘qualified
11 health plan’ means a health plan (within the
12 meaning of section 223(c)(2), without regard to
13 subparagraph (A)(i) thereof) which, under regu-
14 lations prescribed by the Secretary, meets the
15 following requirements:

16 “(i) The plan has coverage for inpa-
17 tient and outpatient care, emergency bene-
18 fits, and physician care.

19 “(ii) The plan has coverage which
20 meaningfully limits individual economic ex-
21 posure to extraordinary medical expenses

22 “(B) EXCLUSION OF CERTAIN PLANS.—

23 The term ‘qualified health plan’ does not in-
24 clude—

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

4 “(ii) any program or benefits referred
5 to in clause (i), (ii), or (iii) of paragraph
6 (1)(B), and

7 “(iii) a Medicare supplemental policy
8 (as defined in section 1882 of the Social
9 Security Act).

10 “(e) REGULATIONS.—The Secretary may prescribe
11 such regulations as may be necessary to carry out this
12 section.”.

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

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

19 (c) ELECTION TO TAKE HEALTH INSURANCE COSTS
20 CREDIT.—Section 35(g) is amended by redesignating
21 paragraphs (9), (10), and (11) as paragraphs (10), (11),
22 and (12), respectively, and by inserting after paragraph
23 (8) the following new paragraph:

24 “(9) ELECTION NOT TO CLAIM CREDIT.—This
25 section shall not apply to a taxpayer for any taxable

1 year if such taxpayer elects to have this section not
2 apply for such taxable year.”.

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

“Sec. 224. Standard deduction for health insurance.

“Sec. 225. Cross reference.”.

7 (e) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to taxable years beginning after
9 December 31, 2017.

10 **SEC. 202. CHANGES TO EXISTING TAX PREFERENCES FOR**
11 **MEDICAL COVERAGE AND COSTS FOR INDI-**
12 **VIDUALS ELIGIBLE FOR STANDARD DEDUC-**
13 **TION FOR HEALTH INSURANCE.**

14 (a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER
15 TO ACCIDENT AND HEALTH PLANS.—

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

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

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

1 “(2) EXCEPTION FOR INDIVIDUALS COVERED
2 BY MEDICARE, MEDICAID, SCHIP, OR GRAND-
3 FATHERED EMPLOYER PLANS.—Paragraph (1) shall
4 not apply to an individual for any taxable year if
5 such individual is not an eligible individual (as de-
6 fined in section 224(d)(1)) for any month during
7 such taxable year by reason of coverage described in
8 section 224(d)(1)(B).”.

9 (2) CONFORMING AMENDMENTS.—

10 (A) Section 106(b)(1) is amended—

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

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

17 (B) Section 106(d)(1) is amended—

18 (i) by inserting “gross income does
19 not include” before “amounts contrib-
20 uted”, and

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

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

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

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

6 (c) **EFFECTIVE DATE.**—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 2017.

9 **SEC. 203. EXCLUSION OF STANDARD DEDUCTION FOR**
10 **HEALTH INSURANCE FROM EMPLOYMENT**
11 **TAXES.**

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

14 **“SEC. 3512. EXCLUSION OF STANDARD DEDUCTION FROM**
15 **EMPLOYMENT TAXES.**

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

21 “(1) The amount of wages determined under
22 section 3121(a).

23 “(2) The amount of compensation determined
24 under section 3231(e).

1 “(3) The amount of wages determined under
2 section 3306(b).

3 “(b) DETERMINATION OF STANDARD DEDUCTION
4 ALLOCABLE TO A PERIOD.—For purposes of subsection
5 (a)—

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

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

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

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

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

1 “(1) IN GENERAL.—If the application of this
2 subsection results in an incorrect amount being
3 treated as wages or compensation for purposes of
4 chapter 21, 22, or 23, whichever is applicable, with
5 respect to any employee for one or more periods end-
6 ing within a taxable year of the employee—

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

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

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

23 “(3) RULES FOR REPORTING AND COLLECTION
24 OF TAX.—Any tax required to be paid by an em-
25 ployee under paragraph (1)(B) shall be included

1 with the employee's return of Federal income tax for
2 the taxable year.

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

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

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

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

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

17 “(B) the amount of any reduction in wages
18 or compensation for such period under section
19 3512.

20 “(2) DETERMINATION OF STANDARD DEDUC-
21 TION ALLOCABLE TO A PERIOD.—For purposes of
22 paragraph (1), the portion of the standard deduction
23 allocable to any period shall be determined in a man-
24 ner similar to the manner under section 3512.”.

25 (c) CONFORMING AMENDMENTS.—

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

4 (2) Subsection (a) of section 209 of the Social
5 Security Act (42 U.S.C. 409) is amended by striking
6 “or” at the end of paragraph (19), by striking the
7 period at the end of paragraph (20) and inserting “;
8 or”, and by inserting after paragraph (20) the fol-
9 lowing new paragraph:

10 “(21) any amount excluded from wages under
11 section 3512(a) of the Internal Revenue Code of
12 1986 (relating to exclusion of standard deduction
13 from employment taxes).”.

14 (3) Section 1324(b)(2) of title 31, United
15 States Code, is amended by inserting “, or the credit
16 under section 3512(c)(2) of such Code” before the
17 period at the end.

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

23 “(C) by disregarding the exclusion from
24 wages in subsection (a)(21),”.

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

“Sec. 3512. Exclusion of standard deduction from employment taxes.”.

4 (d) **EFFECTIVE DATES.**—

5 (1) **IN GENERAL.**—Except as provided in para-
6 graph (2), the amendments made by this section
7 shall apply to remuneration paid or accrued for peri-
8 ods on or after December 31, 2017.

9 (2) **RECONCILIATION AND SELF-EMPLOYED.**—

10 Sections 3512(c) and (d)(2) of the Internal Revenue
11 Code of 1986 (as added by subsection (a)), and the
12 amendments made by subsection (b), shall apply to
13 taxable years beginning after December 31, 2017.

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

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

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

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

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

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

5 “(2) contains—

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

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

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

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

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

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

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

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

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

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

20 (c) APPLICATION TO RETIREES.—Subsection (a) of
21 section 6051 is amended by adding at the end the fol-
22 lowing: “In the case of a retiree, this section shall (to the
23 extent established by the Secretary by regulation) apply
24 only with respect to paragraph (15).”.

25 (d) ASSESSABLE PENALTIES.—

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

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

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

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

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

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

20 (f) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to years beginning after December
22 31, 2017.

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

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

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

14 (b) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply to taxable years beginning after
16 December 31, 2017.

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

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

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

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

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

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

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

10 (b) EFFECTIVE DATE.—The amendment made by
11 this section shall apply to taxable years beginning after
12 December 31, 2017.

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

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

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

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

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

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 2017.

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

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

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

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

4 (b) EFFECTIVE DATE.—The amendment made by
5 this section shall apply to taxable years beginning after
6 December 31, 2017.

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

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

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

22 (b) EFFECTIVE DATE.—The amendment made by
23 this section shall apply to taxable years beginning after
24 December 31, 2017.

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

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

5 “(E) SPECIAL RULE FOR INDIVIDUALS EL-
6 IGIBLE FOR ASSISTANCE UNDER TRICARE.—For
7 purposes of subparagraph (A)(ii), an individual
8 shall not be treated as covered under a health
9 plan described in such subparagraph merely be-
10 cause the individual is eligible to receive hos-
11 pital care, medical services, or prescription
12 drugs under chapter 55 of title 10, United
13 States Code, under TRICARE Extra or
14 TRICARE Standard and such individual is not
15 enrolled in TRICARE Prime.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 this section shall apply to taxable years beginning after
18 December 31, 2017.

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

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

23 (1) by striking “and” at the end of clause (ii),
24 (2) by striking the period at the end of clause
25 (iii) and inserting “, and”, and

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

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

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

21 “(II) coverage that, after the
22 qualified HSA distribution is made,
23 does not pay or reimburse any med-
24 ical expense incurred after the quali-
25 fied HSA distribution is made other

1 than preventive care as defined in
2 paragraph (2)(C),

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

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

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

21 “(VI) coverage that, after the
22 qualified HSA distribution is made, is
23 suspended, pursuant to an election
24 made on or before the date the indi-
25 vidual elects a qualified HSA distribu-

1 tion or, if later, on the date of the in-
2 dividual enrolls in a high deductible
3 health plan, that does not pay or re-
4 imburse, at any time, any medical ex-
5 pense incurred during the suspension
6 period except as defined in the pre-
7 ceding subclauses of this clause.”.

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

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

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

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

1 ant to a qualified HSA distribution (as defined
2 in section 106(e)(2)).”.

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

6 “(2) QUALIFIED HSA DISTRIBUTION.—

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

13 “(i) the balance in such arrangement
14 as of the date of such distribution, or

15 “(ii) the amount determined under
16 subparagraph (B).

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

19 “(B) DOLLAR LIMITATIONS.—

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

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

6 “(I) the applicable amount di-
7 vided by 12, multiplied by

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

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

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

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

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

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

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

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

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

1 rangement or health reimbursement arrangement,
2 and without requiring any change in coverage to in-
3 dividuals who do not enroll in a high deductible
4 health plan.”.

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

9 “(6) COST-OF-LIVING ADJUSTMENT.—

10 “(A) IN GENERAL.—In the case of any
11 taxable year beginning in a calendar year after
12 2017, each of the dollar amounts in paragraph
13 (2)(B)(iii) shall be increased by an amount
14 equal to such dollar amount, multiplied by the
15 cost-of-living adjustment determined under sec-
16 tion 1(f)(3) for the calendar year in which such
17 taxable year begins by substituting ‘calendar
18 year 2016’ for ‘calendar year 1992’ in subpara-
19 graph (B) thereof.

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

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

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

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

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

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

20 (i) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 2017.

1 **SEC. 227. PURCHASE OF HEALTH INSURANCE FROM HSA**
2 **ACCOUNT.**

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

5 “(2) QUALIFIED MEDICAL EXPENSES.—

6 “(A) IN GENERAL.—The term ‘qualified
7 medical expenses’ means, with respect to an ac-
8 count beneficiary, amounts paid by such bene-
9 fiary for medical care (as defined in section
10 213(d)) for any individual covered by a high de-
11 ductible health plan of the account beneficiary,
12 but only to the extent such amounts are not
13 compensated for by insurance or otherwise.

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

18 “(C) EXCEPTIONS.—Subparagraph (B)
19 shall not apply to any expense for coverage
20 under—

21 “(i) a health plan during any period
22 of continuation coverage required under
23 any Federal law,

24 “(ii) a qualified long-term care insur-
25 ance contract (as defined in section
26 7702B(b)),

1 “(iii) a health plan during any period
2 in which the individual is receiving unem-
3 ployment compensation under any Federal
4 or State law,

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

6 “(v) any health insurance under title
7 XVIII of the Social Security Act, other
8 than a Medicare supplemental policy (as
9 defined in section 1882 of such Act).”.

10 (b) EFFECTIVE DATE.—The amendment made by
11 this section shall apply with respect to insurance pur-
12 chased after the date of the enactment of this Act in tax-
13 able years beginning after December 31, 2017.

14 **SEC. 228. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**
15 **INCURRED BEFORE ESTABLISHMENT OF AC-**
16 **COUNT.**

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

20 “(D) CERTAIN MEDICAL EXPENSES IN-
21 CURRED BEFORE ESTABLISHMENT OF ACCOUNT
22 TREATED AS QUALIFIED.—An expense shall not
23 fail to be treated as a qualified medical expense
24 solely because such expense was incurred before

1 the establishment of the health savings account
2 if such expense was incurred—

3 “(i) during either—

4 “(I) the taxable year in which the
5 health savings account was estab-
6 lished, or

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

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

21 (b) EFFECTIVE DATE.—The amendment made by
22 this section shall apply to taxable years beginning after
23 December 31, 2017.

1 **SEC. 229. PREVENTIVE CARE PRESCRIPTION DRUG CLARI-**
2 **FICATION.**

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

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

13 **SEC. 230. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**
14 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**
15 **MENT FUNDS.**

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

19 “(r) TREATMENT OF HEALTH SAVINGS AC-
20 COUNTS.—For purposes of this section, any health savings
21 account (as described in section 223 of the Internal Rev-
22 enue Code of 1986) shall be treated in the same manner
23 as an individual retirement account described in section
24 408 of such Code.”.

25 (b) EFFECTIVE DATE.—The amendment made by
26 this section shall apply to cases commencing under title

1 11, United States Code, after the date of the enactment
2 of this Act.

3 **SEC. 231. ADMINISTRATIVE ERROR CORRECTION BEFORE**
4 **DUE DATE OF RETURN.**

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

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

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

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

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

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall take effect on the date of the enactment
3 of this Act.

4 **SEC. 232. REAUTHORIZATION OF MEDICAID HEALTH OP-**
5 **PORTUNITY ACCOUNTS.**

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

8 (1) in subsection (a)—

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

11 “(2) INITIAL DEMONSTRATION.—The dem-
12 onstration program under this section shall begin
13 again on January 1, 2016. The Secretary shall ap-
14 prove States to conduct demonstration programs
15 under this section for a 5-year period, with each
16 State demonstration program covering one or more
17 geographic areas specified by the State. With respect
18 to a State, after the initial 5-year period of any
19 demonstration program conducted under this section
20 by the State, unless the Secretary finds, taking into
21 account cost-effectiveness and quality of care, that
22 the State demonstration program has been unsuc-
23 cessful, the demonstration program may be extended
24 or made permanent in the State.”; and

1 (B) in paragraph (3), in the matter pre-
2 ceding subparagraph (A)—

3 (i) by striking “not”; and

4 (ii) by striking “unless” and inserting
5 “if”;

6 (2) in subsection (b)—

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

12 (B) by striking paragraphs (4), (5), and
13 (6);

14 (3) in subsection (c)—

15 (A) in paragraph (6), by striking “Subject
16 to subparagraphs (D) and (E)” and inserting
17 “Subject to subparagraph (D)”;

18 (B) by striking paragraphs (3) and (4);
19 and

20 (C) by redesignating paragraphs (5)
21 through (8) as paragraphs (3) through (6), re-
22 spectively; and

23 (4) in subsection (d)—

24 (A) in paragraph (2), by striking subpara-
25 graph (E); and

1 (B) in paragraph (3)—

2 (i) in subparagraph (A)(ii), by strik-
3 ing “Subject to subparagraph (B)(ii), in”
4 and inserting “In”; and

5 (ii) by striking subparagraph (B) and
6 inserting the following:

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

14 “(i) no additional contribution shall be
15 made into the account under paragraph
16 (2)(A)(i); and

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

1 (b) CONFORMING AMENDMENT.—Section 613 of the
2 Children’s Health Insurance Program Reauthorization
3 Act of 2009 (Public Law 111–3; 42 U.S.C. 1396u–8 note)
4 is repealed.

5 **SEC. 233. MEMBERS OF HEALTH CARE SHARING MIN-**
6 **ISTRIES ELIGIBLE TO ESTABLISH HEALTH**
7 **SAVINGS ACCOUNTS.**

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

10 “(i) APPLICATION TO HEALTH CARE SHARING MIN-
11 ISTRIES.—For purposes of this section, membership in a
12 health care sharing ministry (as defined in section
13 5000A(d)(2)(B)(ii)) shall be treated as coverage under a
14 high deductible health plan.”.

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. 234. HIGH DEDUCTIBLE HEALTH PLANS RENAMED**
19 **HSA QUALIFIED PLANS.**

20 (a) IN GENERAL.—Section 223, as amended by this
21 subtitle, is amended by striking “high deductible health
22 plan” each place it appears and inserting “HSA qualified
23 health plan”.

24 (b) CONFORMING AMENDMENTS.—

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

5 (2) The heading for paragraph (2) of section
6 223(c) is amended by striking “HIGH DEDUCTIBLE
7 HEALTH PLAN” and inserting “HSA QUALIFIED
8 HEALTH PLAN”.

9 (3) Section 408(d)(9) is amended—

10 (A) by striking “high deductible health
11 plan” each place it appears in subparagraph
12 (C) and inserting “HSA qualified health plan”,
13 and

14 (B) by striking “HIGH DEDUCTIBLE
15 HEALTH PLAN” in the heading of subparagraph
16 (D) and inserting “HSA QUALIFIED HEALTH
17 PLAN”.

18 **SEC. 235. TREATMENT OF DIRECT PRIMARY CARE SERVICE**

19 **ARRANGEMENTS.**

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

22 “(6) TREATMENT OF DIRECT PRIMARY CARE
23 SERVICE ARRANGEMENTS.—An arrangement under
24 which an individual is provided coverage restricted to

1 primary care services in exchange for a fixed peri-
 2 odic fee—

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

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

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

10 **SEC. 236. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL**

11 **FITNESS PROGRAMS TREATED AS MEDICAL**

12 **CARE.**

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

16 “(12) EXERCISE EQUIPMENT AND PHYSICAL
 17 FITNESS PROGRAMS.—

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

20 “(i) to purchase or use equipment
 21 used in a program (including a self-di-
 22 rected program) of physical exercise,

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

1 “(iii) for membership dues in a fitness
2 club the primary purpose of which is to
3 provide access to equipment and facilities
4 for physical exercise.

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

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

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

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

17 “(13) NUTRITIONAL AND DIETARY SUPPLE-

18 MENTS.—

19 “(A) IN GENERAL.—The term ‘medical
20 care’ shall include amounts paid to purchase
21 herbs, vitamins, minerals, homeopathic rem-
22 edies, meal replacement products, and other di-
23 etary and nutritional supplements.

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

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

3 “(C) MEAL REPLACEMENT PRODUCT.—

4 For purposes of this paragraph, the term ‘meal
5 replacement product’ means any product that—

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

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

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

19 (a) IN GENERAL.—Subsection (d) of section 213, as
20 amended by this Act, is amended by adding at the end
21 the following new paragraph:

22 “(14) PERIODIC PROVIDER FEES.—The term
23 ‘medical care’ shall include periodic fees paid to a
24 primary care physician for the right to receive med-
25 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. 239. INCREASE THE MAXIMUM CONTRIBUTION LIMIT**
5 **TO AN HSA TO MATCH DEDUCTIBLE AND**
6 **OUT-OF-POCKET EXPENSE LIMITATION.**

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

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

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. 240. CHILD HEALTH SAVINGS ACCOUNT.**

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

22 “(j) CHILD HEALTH SAVINGS ACCOUNTS.—

23 “(1) IN GENERAL.—In the case of an indi-
24 vidual, in addition to any deduction allowed under
25 subsection (a) for any taxable year, there shall be al-

1 lowed as a deduction under this section an amount
2 equal to the aggregate amount paid in cash by the
3 taxpayer during the taxable year to a child health
4 savings account of a child of the taxpayer.

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

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

15 “(A) such account was established for the
16 benefit of the child before the child attains the
17 age of 5, and

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

24 “(4) TREATMENT OF ACCOUNT BEFORE AGE
25 18.—For purposes of this section, except as other-

1 wise provided in this subsection, a child health sav-
2 ings account established for the benefit of the child
3 of a taxpayer shall be treated as a health savings ac-
4 count of the taxpayer until the child attains the age
5 of 18, after which such account shall be treated as
6 a health savings account of the child.

7 “(5) DISTRIBUTIONS.—

8 “(A) IN GENERAL.—In the case of a child
9 health savings account established under this
10 section for the benefit of a child of a tax-
11 payer—

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

20 “(ii) AGE 18 AND OLDER.—Any
21 amount paid or distributed out of such ac-
22 count after the child has attained the age
23 of 18 may only be treated as used to pay
24 qualified medical expenses to the extent
25 such child is not covered as a dependent

1 under insurance (other than permitted in-
2 surance) of a parent.

3 “(B) EXCEPTIONS FOR DISABILITY OR
4 DEATH OF CHILD.—If the child becomes dis-
5 abled within the meaning of section 72(m)(7) or
6 dies—

7 “(i) subparagraph (A) shall not apply
8 to any subsequent payment or distribution,
9 and

10 “(ii) the taxpayer may rollover the
11 amount in such account to an individual
12 retirement plan of the taxpayer, to any
13 health savings account of the taxpayer, or
14 to any child health savings account of any
15 other child of the taxpayer.

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

21 “(6) REGULATIONS.—The Secretary shall pre-
22 scribe such regulations as may be necessary to carry
23 out the purposes of this subsection, including rules
24 for determining application of this subsection in the
25 case of legal guardians and in the case of parents

1 of a child who file separately, are separated, or are
2 not married.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 2017.

6 **SEC. 241. ALLOWING MINIMUM DISTRIBUTIONS FROM TAX-**
7 **DEFERRED RETIREMENT ACCOUNTS TO BE**
8 **DEPOSITED INTO HSAS.**

9 (a) TRANSFER FROM RETIREMENT PLAN.—

10 (1) INDIVIDUAL RETIREMENT ACCOUNTS.—Sec-
11 tion 408(d) is amended by adding at the end the fol-
12 lowing new paragraph:

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

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

22 “(B) QUALIFIED HSA TRANSFER.—For
23 purposes of this paragraph, the term ‘qualified
24 HSA transfer’ means any distribution from an
25 individual retirement plan—

1 “(i) to a health savings account of the
2 individual in a direct trustee-to-trustee
3 transfer, and

4 “(ii) to the extent such distribution
5 does not exceed the required minimum dis-
6 tribution determined under section
7 401(a)(9) for the distribution calendar
8 year ending during the taxable year.

9 “(C) APPLICATION OF SECTION 72.—Not-
10 withstanding section 72, in determining the ex-
11 tent to which an amount is treated as a dis-
12 tribution for purposes of paragraph (1), the en-
13 tire amount of the distribution shall be treated
14 as includible in gross income without regard to
15 paragraph (1) to the extent that such amount
16 does not exceed the aggregate amount which
17 would have been so includible if all amounts in
18 all individual retirement plans of the individual
19 were distributed during such taxable year and
20 all such plans were treated as 1 contract for
21 purposes of determining under section 72 the
22 aggregate amount which would have been so in-
23 cludible. Proper adjustments shall be made in
24 applying section 72 to other distributions in
25 such taxable year and subsequent taxable years.

1 “(D) COORDINATION.—An election may
2 not be made under subparagraph (A) for a tax-
3 able year for which an election is in effect
4 under paragraph (9).”.

5 (2) OTHER RETIREMENT PLANS.—Section 402
6 of the Internal Revenue Code of 1986 is amended by
7 adding at the end the following new subsection:

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

10 “(1) IN GENERAL.—In the case of an individual
11 who has attained the age of 70½ and who elects the
12 application of this subsection for a taxable year,
13 gross income of the individual for the taxable year
14 does not include a qualified HSA transfer to the ex-
15 tent such transfer is otherwise includible in gross in-
16 come.

17 “(2) QUALIFIED HSA TRANSFER.—For pur-
18 poses of this subsection, the term ‘qualified HSA
19 transfer’ means any distribution from an individual
20 retirement plan—

21 “(A) to a health savings account of the in-
22 dividual in a direct trustee-to-trustee transfer,
23 and

24 “(B) to the extent such distribution does
25 not exceed the required minimum distribution

1 determined under section 401(a)(9) for the dis-
2 tribution calendar year ending during the tax-
3 able year.

4 “(3) APPLICATION OF SECTION 72.—Notwith-
5 standing section 72, in determining the extent to
6 which an amount is treated as a distribution for
7 purposes of paragraph (1), the entire amount of the
8 distribution shall be treated as includible in gross in-
9 come without regard to paragraph (1) to the extent
10 that such amount does not exceed the aggregate
11 amount which would have been so includible if all
12 amounts in all eligible retirement plans of the indi-
13 vidual were distributed during such taxable year and
14 all such plans were treated as 1 contract for pur-
15 poses of determining under section 72 the aggregate
16 amount which would have been so includible. Proper
17 adjustments shall be made in applying section 72 to
18 other distributions in such taxable year and subse-
19 quent taxable years.

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

25 (b) TRANSFER TO HEALTH SAVINGS ACCOUNT.—

1 (1) IN GENERAL.—Subparagraph (A) of section
2 223(d)(1) is amended by striking “or” at the end of
3 clause (i), by striking the period at the end of clause
4 (ii)(II) and inserting “, or”, and by adding at the
5 end the following new clause:

6 “(iii) unless it is in a qualified HSA
7 transfer described in section 408(d)(10) or
8 402(m).”.

9 (2) EXCISE TAX INAPPLICABLE TO QUALIFIED
10 HSA TRANSFER.—Paragraph (1) of section 4973(g)
11 is amended by inserting “or in a qualified HSA
12 transfer described in section 408(d)(10) or 402(m)”
13 after “or 223(f)(5)”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to distributions made after the
16 date of the enactment of this Act, in taxable years ending
17 after such date.

18 **SEC. 242. DISTRIBUTIONS FOR ABORTION EXPENSES FROM**
19 **HEALTH SAVINGS ACCOUNTS INCLUDED IN**
20 **GROSS INCOME.**

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

24 “(9) EXCEPTION FOR CERTAIN ABORTION EX-
25 PENSES.—

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

6 “(B) EXCEPTIONS.—Subparagraph (A)
7 shall not apply to—

8 “(i) an abortion—

9 “(I) in the case of a pregnancy
10 that is the result of an act of rape or
11 incest, or

12 “(II) in the case where a woman
13 suffers from a physical disorder, phys-
14 ical injury, or physical illness that
15 would, as certified by a physician,
16 place the woman in danger of death
17 unless an abortion is performed, in-
18 cluding a life-endangering physical
19 condition caused by or arising from
20 the pregnancy, and

21 “(ii) the treatment of any infection,
22 injury, disease, or disorder that has been
23 caused by or exacerbated by the perform-
24 ance of an abortion.”.

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 **Subtitle C—Enhanced Wellness** 5 **Incentives**

6 **SEC. 251. PROVIDING FINANCIAL INCENTIVES FOR TREAT-** 7 **MENT COMPLIANCE.**

8 (a) LIMITATION ON EXCEPTION FOR WELLNESS
9 PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

10 (1) EMPLOYEE RETIREMENT INCOME SECURITY
11 ACT OF 1974 AMENDMENT.—Section 702(b)(2) of the
12 Employee Retirement Income Security Act of 1974
13 (29 U.S.C. 1182(b)(2)) is amended by adding at the
14 end the following flush sentence:

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

22 (2) PHSA AMENDMENT.—Section 2705(b)(2)
23 of the Public Health Service Act (42 U.S.C. 300gg-
24 4(b)(2)) is amended by adding at the end the fol-
25 lowing flush sentence:

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

8 (3) IRC AMENDMENT.—Section 9802(b)(2) of
9 the Internal Revenue Code of 1986 is amended by
10 adding at the end the following flush sentence:

11 “In applying subparagraph (B), a group health plan
12 may vary premiums and cost-sharing by up to 50
13 percent of the value of the benefits under the plan
14 based on participation (or lack of participation) in a
15 standards-based wellness program.”.

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

1 **TITLE III—IMPROVING ACCESS**
2 **TO INSURANCE FOR VULNER-**
3 **ABLE AMERICANS**

4 **Subtitle A—Eliminating Barriers to**
5 **Insurance Coverage**

6 **SEC. 301. ELIMINATION OF CERTAIN REQUIREMENTS FOR**
7 **GUARANTEED AVAILABILITY IN INDIVIDUAL**
8 **MARKET.**

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

12 (1) in paragraph (1)—

13 (A) by striking “(1)(A)” and inserting
14 “(1)”; and

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

17 (2) by adding “and” at the end of paragraph
18 (2);

19 (3) in paragraph (3)—

20 (A) by striking “(1)(A)” and inserting
21 “(1)”; and

22 (B) by striking the semicolon at the end
23 and inserting a period; and

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

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall take effect 2 years after the date of
3 the enactment of this Act.

4 **Subtitle B—Ensuring Coverage for**
5 **Individuals With Preexisting**
6 **Conditions and Multiple Health**
7 **Care Needs Through High-Risk**
8 **Pools**

9 **SEC. 311. IMPROVEMENT OF HIGH-RISK POOLS.**

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

12 (1) in subsection (a), by adding at the end the
13 following: “The Secretary shall provide from the
14 funds appropriated under subsection (d)(3)(A) a
15 grant of up to \$5,000,000 to each State that has
16 not created a qualified high-risk pool as of Sep-
17 tember 1, 2017, for the State’s costs of creation and
18 initial operation of such a pool.”;

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

22 (3) in subsection (b)(3), by inserting “with re-
23 spect to funds made available for fiscal years before
24 fiscal year 2016,” after “applicable standard risks,”;

1 (4) by adding at the end of subsection (b) the
2 following new paragraph:

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

5 “(A) IN GENERAL.—Notwithstanding any
6 other provision of law, effective upon the date
7 of the enactment of this paragraph, only citi-
8 zens and nationals of the United States shall be
9 eligible to participate in a qualified high-risk
10 pool that receives funds under this section.

11 “(B) CONDITION OF PARTICIPATION.—As
12 a condition of a State receiving such funds
13 under this subsection for a fiscal year beginning
14 with fiscal year 2018, the Secretary shall re-
15 quire the State to certify, to the satisfaction of
16 the Secretary, that such State requires all ap-
17 plicants for coverage in the qualified high-risk
18 pool to provide satisfactory documentation of
19 citizenship or nationality in a manner consistent
20 with section 1903(x) of the Social Security Act.

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

1 (5) in subsection (d)—

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

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

7 (C) by redesignating paragraphs (3)
8 through (5) as paragraphs (5) through (7), re-
9 spectively; and

10 (D) by inserting after paragraph (2) the
11 following:

12 “(3) AUTHORIZATION OF APPROPRIATIONS FOR
13 FISCAL YEAR 2018.—There are authorized to be ap-
14 propriated for fiscal year 2018—

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

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

20 “(4) AUTHORIZATION OF APPROPRIATIONS FOR
21 FISCAL YEARS 2019 THROUGH 2027.—There are au-
22 thorized to be appropriated \$2,500,000,000 for each
23 of fiscal years 2019 through 2027 which, subject to
24 paragraph (6), shall be made available for allotments
25 under subsection (b)(2).”.

1 **TITLE IV—ENCOURAGING A**
2 **MORE COMPETITIVE HEALTH**
3 **CARE MARKET**

4 **Subtitle A—Expanding Patient**
5 **Choice**

6 **SEC. 401. COOPERATIVE GOVERNING OF INDIVIDUAL**
7 **HEALTH INSURANCE COVERAGE.**

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

24 “(5) APPLICABLE STATE AUTHORITY.—The
25 term ‘applicable State authority’ means, with respect

1 to a health insurance issuer in a State, the State in-
2 surance commissioner or official or officials des-
3 ignated by the State to enforce the requirements of
4 this title for the State with respect to the issuer.

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

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

13 “(B) to pay other obligations in the normal
14 course of business.

15 “(7) COVERED LAWS.—

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

20 “(i) individual health insurance cov-
21 erage issued by a health insurance issuer;

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

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

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

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

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

23 “(8) STATE.—The term ‘State’ means the 50
24 States and includes the District of Columbia, Puerto

1 Rico, the Virgin Islands, Guam, American Samoa,
2 and the Northern Mariana Islands.

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 quest 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.—Subject to section 601(d) of the
5 American Health Care Reform Act of 2017, the covered
6 laws of the primary State shall apply to individual health
7 insurance coverage offered by a health insurance issuer
8 in the primary State and in any secondary State, but only
9 if the coverage and issuer comply with the conditions of
10 this section with respect to the offering of coverage in any
11 secondary State.

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

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

1 “(A) to pay, on a nondiscriminatory basis,
2 applicable premium and other taxes (including
3 high-risk pool assessments) which are levied on
4 insurers and surplus lines insurers, brokers, or
5 policyholders under the laws of the State;

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

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

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

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

1 “(D) to comply with a lawful order
2 issued—

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

8 “(ii) in a voluntary dissolution pro-
9 ceeding;

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

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

20 “(G) to comply with any State law regard-
21 ing fraud and abuse (as defined in section
22 2795(10)), except that if the State seeks an in-
23 junction regarding the conduct described in this
24 subparagraph, such injunction must be obtained
25 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:

“NOTICE

1
2 “This policy is issued by _____ and is gov-
3 erned by the laws and regulations of the State of
4 _____, and it has met all the laws of that State as
5 determined by that State’s Department of Insurance. This
6 policy may be less expensive than others because it is not
7 subject to all of the insurance laws and regulations of the
8 State of _____, including coverage of some services
9 or benefits mandated by the law of the State of
10 _____. Additionally, this policy is not subject to all
11 of the consumer protection laws or restrictions on rate
12 changes of the State of _____. As with all insurance
13 products, before purchasing this policy, you should care-
14 fully review the policy and determine what health care
15 services the policy covers and what benefits it provides,
16 including any exclusions, limitations, or conditions for
17 such services or benefits.’.

18 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
19 AND PREMIUM INCREASES.—

20 “(1) IN GENERAL.—For purposes of this sec-
21 tion, a health insurance issuer that provides indi-
22 vidual health insurance coverage to an individual
23 under this part in a primary or secondary State may
24 not upon renewal—

1 “(A) move or reclassify the individual in-
2 sured under the health insurance coverage from
3 the class such individual is in at the time of
4 issue of the contract based on the health-status
5 related factors of the individual; or

6 “(B) increase the premiums assessed the
7 individual for such coverage based on a health
8 status-related factor or change of a health sta-
9 tus-related factor or the past or prospective
10 claim experience of the insured individual.

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

14 “(A) from terminating or discontinuing
15 coverage or a class of coverage in accordance
16 with subsections (b) and (c) of section 2742;

17 “(B) from raising premium rates for all
18 policy holders within a class based on claims ex-
19 perience;

20 “(C) from changing premiums or offering
21 discounted premiums to individuals who engage
22 in wellness activities at intervals prescribed by
23 the issuer, if such premium changes or incen-
24 tives—

1 “(i) are disclosed to the consumer in
2 the insurance contract;

3 “(ii) are based on specific wellness ac-
4 tivities that are not applicable to all indi-
5 viduals; and

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

8 “(D) from reinstating lapsed coverage; or

9 “(E) from retroactively adjusting the rates
10 charged an insured individual if the initial rates
11 were set based on material misrepresentation by
12 the individual at the time of issue.

13 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
14 STATE.—A health insurance issuer may not offer for sale
15 individual health insurance coverage in a secondary State
16 unless that coverage is currently offered for sale in the
17 primary State.

18 “(f) LICENSING OF AGENTS OR BROKERS FOR
19 HEALTH INSURANCE ISSUERS.—Any State may require
20 that a person acting, or offering to act, as an agent or
21 broker for a health insurance issuer with respect to the
22 offering of individual health insurance coverage obtain a
23 license from that State, with commissions or other com-
24 pensation subject to the provisions of the laws of that
25 State, except that a State may not impose any qualifica-

1 tion or requirement which discriminates against a non-
2 resident agent or broker.

3 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
4 SURANCE COMMISSIONER.—Each health insurance issuer
5 issuing individual health insurance coverage in both pri-
6 mary and secondary States shall submit—

7 “(1) to the insurance commissioner of each
8 State in which it intends to offer such coverage, be-
9 fore it may offer individual health insurance cov-
10 erage in such State—

11 “(A) a copy of the plan of operation or fea-
12 sibility study or any similar statement of the
13 policy being offered and its coverage (which
14 shall include the name of its primary State and
15 its principal place of business);

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

18 “(C) written notice from the issuer of the
19 issuer’s compliance with all the laws of the pri-
20 mary State; and

21 “(2) to the insurance commissioner of each sec-
22 ondary State in which it offers individual health in-
23 surance coverage, a copy of the issuer’s quarterly fi-
24 nancial statement submitted to the primary State,
25 which statement shall be certified by an independent

1 public accountant and contain a statement of opin-
2 ion on loss and loss adjustment expense reserves
3 made by—

4 “(A) a member of the American Academy
5 of Actuaries; or

6 “(B) a qualified loss reserve specialist.

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

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

14 “(2) the solicitation or sale of individual health
15 insurance coverage that violates the requirements of
16 the law of a secondary State which are described in
17 subparagraphs (A) through (H) of section
18 2796(b)(1).

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

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

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

8 “(2) COURTS OF COMPETENT JURISDICTION.—
9 If a State seeks an injunction regarding the conduct
10 described in paragraphs (1) and (2) of subsection
11 (h), such injunction must be obtained from a Fed-
12 eral or State court of competent jurisdiction.

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

16 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
17 this section shall be construed to affect the applicability
18 of State laws generally applicable to persons or corpora-
19 tions.

20 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
21 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
22 health insurance issuer is offering coverage in a primary
23 State that does not accommodate residents of secondary
24 States or does not provide a working mechanism for resi-
25 dents of a secondary State, and the issuer is offering cov-

1 erage under this part in such secondary State which has
2 not adopted a qualified high-risk pool as its acceptable al-
3 ternative mechanism (as defined in section 2744(c)(2)),
4 the issuer shall, with respect to any individual health in-
5 surance coverage offered in a secondary State under this
6 part, comply with the guaranteed availability requirements
7 for eligible individuals in section 2741.

8 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
9 **BEFORE ISSUER MAY SELL INTO SECONDARY**
10 **STATES.**

11 “A health insurance issuer may not offer, sell, or
12 issue individual health insurance coverage in a secondary
13 State if the State insurance commissioner does not use
14 a risk-based capital formula for the determination of cap-
15 ital and surplus requirements for all health insurance
16 issuers.

17 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
18 **DURES.**

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

23 “(1) both the secondary State and the primary
24 State have legislation or regulations in place estab-
25 lishing an independent review process for individuals

1 who are covered by individual health insurance cov-
2 erage, or

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

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

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

23 “(A) each independent medical reviewer
24 meets the qualifications described in paragraphs
25 (2) and (3);

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

6 “(C) compensation provided by the issuer
7 to each reviewer is consistent with paragraph
8 (6).

9 “(2) LICENSURE AND EXPERTISE.—Each inde-
10 pendent medical reviewer shall be a physician
11 (allopathic or osteopathic) or health care profes-
12 sional who—

13 “(A) is appropriately credentialed or li-
14 censed in one or more States to deliver health
15 care services; and

16 “(B) typically treats the condition, makes
17 the diagnosis, or provides the type of treatment
18 under review.

19 “(3) INDEPENDENCE.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), each independent medical reviewer
22 in a case shall—

23 “(i) not be a related party (as defined
24 in paragraph (7));

1 “(ii) not have a material familial, fi-
2 nancial, or professional relationship with
3 such a party; and

4 “(iii) not otherwise have a conflict of
5 interest with such a party (as determined
6 under regulations).

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

9 “(i) prohibit an individual, solely on
10 the basis of affiliation with the issuer,
11 from serving as an independent medical re-
12 viewer if—

13 “(I) a non-affiliated individual is
14 not reasonably available;

15 “(II) the affiliated individual is
16 not involved in the provision of items
17 or services in the case under review;

18 “(III) the fact of such an affili-
19 ation is disclosed to the issuer and the
20 enrollee (or authorized representative)
21 and neither party objects; and

22 “(IV) the affiliated individual is
23 not an employee of the issuer and
24 does not provide services exclusively or
25 primarily to or on behalf of the issuer;

1 “(ii) prohibit an individual who has
2 staff privileges at the institution where the
3 treatment involved takes place from serv-
4 ing as an independent medical reviewer
5 merely on the basis of such affiliation if
6 the affiliation is disclosed to the issuer and
7 the enrollee (or authorized representative),
8 and neither party objects; or

9 “(iii) prohibit receipt of compensation
10 by an independent medical reviewer from
11 an entity if the compensation is provided
12 consistent with paragraph (6).

13 “(4) PRACTICING HEALTH CARE PROFESSIONAL
14 IN SAME FIELD.—

15 “(A) IN GENERAL.—In a case involving
16 treatment, or the provision of items or serv-
17 ices—

18 “(i) by a physician, a reviewer shall be
19 a practicing physician (allopathic or osteo-
20 pathic) of the same or similar specialty, as
21 a physician who, acting within the appro-
22 priate scope of practice within the State in
23 which the service is provided or rendered,
24 typically treats the condition, makes the

1 diagnosis, or provides the type of treat-
2 ment under review; or

3 “(ii) by a non-physician health care
4 professional, the reviewer, or at least 1
5 member of the review panel, shall be a
6 practicing non-physician health care pro-
7 fessional of the same or similar specialty
8 as the non-physician health care profes-
9 sional who, acting within the appropriate
10 scope of practice within the State in which
11 the service is provided or rendered, typi-
12 cally treats the condition, makes the diag-
13 nosis, or provides the type of treatment
14 under review.

15 “(B) PRACTICING DEFINED.—For pur-
16 poses of this paragraph, the term ‘practicing’
17 means, with respect to an individual who is a
18 physician or other health care professional, that
19 the individual provides health care services to
20 individual patients on average at least 2 days
21 per week.

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

1 “(6) LIMITATIONS ON REVIEWER COMPENSA-
2 TION.—Compensation provided by the issuer to an
3 independent medical reviewer in connection with a
4 review under this section shall—

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

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

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

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

14 “(B) The enrollee (or authorized represent-
15 ative).

16 “(C) The health care professional that pro-
17 vides the items or services involved in the de-
18 nial.

19 “(D) The institution at which the items or
20 services (or treatment) involved in the denial
21 are provided.

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

1 “(F) Any other party determined under
2 any regulations to have a substantial interest in
3 the denial involved.

4 “(8) DEFINITIONS.—For purposes of this sub-
5 section:

6 “(A) ENROLLEE.—The term ‘enrollee’
7 means, with respect to health insurance cov-
8 erage offered by a health insurance issuer, an
9 individual enrolled with the issuer to receive
10 such coverage.

11 “(B) HEALTH CARE PROFESSIONAL.—The
12 term ‘health care professional’ means an indi-
13 vidual who is licensed, accredited, or certified
14 under State law to provide specified health care
15 services and who is operating within the scope
16 of such licensure, accreditation, or certification.

17 **“SEC. 2799. ENFORCEMENT.**

18 “(a) IN GENERAL.—Subject to subsection (b) and
19 section 601(d) of the American Health Care Reform Act
20 of 2017, with respect to specific individual health insur-
21 ance coverage the primary State for such coverage has sole
22 jurisdiction to enforce the primary State’s covered laws
23 in the primary State and any secondary State.

24 “(b) SECONDARY STATE’S AUTHORITY.—Nothing in
25 subsection (a) shall be construed to affect the authority

1 of a secondary State to enforce its laws as set forth in
2 the exception specified in section 2796(b)(1).

3 “(c) COURT INTERPRETATION.—In reviewing action
4 initiated by the applicable secondary State authority, the
5 court of competent jurisdiction shall apply the covered
6 laws of the primary State.

7 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
8 of individual health insurance coverage offered in a sec-
9 ondary State that fails to comply with the covered laws
10 of the primary State, the applicable State authority of the
11 secondary State may notify the applicable State authority
12 of the primary State.”.

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

17 (c) GAO ONGOING STUDY AND REPORTS.—

18 (1) STUDY.—The Comptroller General of the
19 United States shall conduct an ongoing study con-
20 cerning the effect of the amendment made by sub-
21 section (a) on—

22 (A) the number of uninsured and under-in-
23 sured;

1 (B) the availability and cost of health in-
2 surance policies for individuals with pre-existing
3 medical conditions;

4 (C) the availability and cost of health in-
5 surance policies generally;

6 (D) the elimination or reduction of dif-
7 ferent types of benefits under health insurance
8 policies offered in different States; and

9 (E) cases of fraud or abuse relating to
10 health insurance coverage offered under such
11 amendment and the resolution of such cases.

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

17 **Subtitle B—McCarran-Ferguson**
18 **Reform**

19 **SEC. 411. RESTORING THE APPLICATION OF ANTITRUST**
20 **LAWS TO HEALTH SECTOR INSURERS.**

21 (a) AMENDMENT TO McCARRAN-FERGUSON ACT.—
22 Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013),
23 commonly known as the McCarran-Ferguson Act, is
24 amended by adding at the end the following:

1 “(c)(1) Nothing contained in this Act shall modify,
2 impair, or supersede the operation of any of the antitrust
3 laws with respect to the business of health insurance (in-
4 cluding the business of dental insurance). For purposes
5 of the preceding sentence, the term ‘antitrust laws’ has
6 the meaning given it in subsection (a) of the first section
7 of the Clayton Act, except that such term includes section
8 5 of the Federal Trade Commission Act to the extent that
9 such section 5 applies to unfair methods of competition.

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

13 “(A) the business of life insurance (including
14 annuities); or

15 “(B) the business of property or casualty insur-
16 ance, including but not limited to, any insurance or
17 benefits defined as ‘excepted benefits’ under para-
18 graph (1), subparagraphs (B) or (C) of paragraph
19 (2), or paragraph (3) of section 9832(e) of the In-
20 ternal Revenue Code of 1986 (26 U.S.C. 9832(e))
21 whether offered separately or in combination with
22 insurance or benefits described in paragraph (2)(A)
23 of such section.”.

24 (b) RELATED PROVISION.—For purposes of section
25 5 of the Federal Trade Commission Act (15 U.S.C. 45)

1 to the extent such section applies to unfair methods of
2 competition, section 3(c) of the McCarran-Ferguson Act
3 shall apply with respect to the business of health insurance
4 without regard to whether such business is carried on for
5 profit, notwithstanding the definition of “Corporation”
6 contained in section 4 of the Federal Trade Commission
7 Act.

8 **Subtitle C—Medicare Price** 9 **Transparency**

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

11 **DATA.**

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

15 “(f) PUBLIC AVAILABILITY OF MEDICARE CLAIMS
16 DATA.—

17 “(1) IN GENERAL.—The Secretary shall, to the
18 extent consistent with applicable information, pri-
19 vacy, security, and disclosure laws, including the
20 regulations promulgated under the Health Insurance
21 Portability and Accountability Act of 1996 and sec-
22 tion 552a of title 5, United States Code, make avail-
23 able to the public claims and payment data of the
24 Department of Health and Human Services related

1 to title XVIII, including data on payments made to
2 any provider of services or supplier under such title.

3 “(2) IMPLEMENTATION.—

4 “(A) IN GENERAL.—Not later than De-
5 cember 31, 2017, the Secretary shall promul-
6 gate regulations to carry out this subsection.

7 “(B) REQUIREMENTS.—The regulations
8 promulgated under subparagraph (A) shall en-
9 sure that—

10 “(i) the data described in paragraph
11 (1) is made available to the public through
12 a searchable database that the public can
13 access at no cost;

14 “(ii) such database—

15 “(I) includes the amount paid to
16 each provider of services or supplier
17 under title XVIII, the items or serv-
18 ices for which such payment was
19 made, and the location of the provider
20 of services or supplier;

21 “(II) is organized based on the
22 specialty or the type of provider of
23 services or supplier involved;

1 “(III) is searchable based on the
2 type of items or services furnished;
3 and

4 “(IV) includes a disclaimer that
5 the aggregate data in the database
6 does not reflect on the quality of the
7 items or services furnished or of the
8 provider of services or supplier who
9 furnished the items or services; and

10 “(iii) each provider of services or sup-
11 plier in the database is identified by a
12 unique identifier that is available to the
13 public (such as the National Provider Iden-
14 tifier of the provider of services or sup-
15 plier).

16 “(C) SCOPE OF DATA.—The database shall
17 include data for fiscal year 2018, and each year
18 fiscal year thereafter.”.

19 (b) INFORMATION NOT EXEMPT UNDER THE FREE-
20 DOM OF INFORMATION ACT.—The term “personnel and
21 medical files and similar files the disclosure of which
22 would constitute a clearly unwarranted invasion of per-
23 sonal privacy”, as used in section 552(b)(6) of title 5,
24 United States Code, does not include the information re-
25 quired to be made available to the public under section

1 1128J(f) of the Social Security Act, as added by sub-
2 section (a).

3 **Subtitle D—State Transparency**
4 **Portals**

5 **SEC. 431. PROVIDING INFORMATION ON HEALTH COV-**
6 **ERAGE OPTIONS AND HEALTH CARE PRO-**
7 **VIDERS.**

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

13 (1) on health insurance plans that have been
14 certified to be available for purchase in that State;
15 and

16 (2) on price and quality information on health
17 care providers (including physicians, hospitals, and
18 other health care institutions).

19 (b) PROHIBITIONS.—

20 (1) DIRECT ENROLLMENT.—A plan portal may
21 not directly enroll individuals in health insurance
22 plans or under a State Medicaid plan or a State
23 children’s health insurance plan.

24 (2) CONFLICTS OF INTEREST.—

1 (A) COMPANIES.—A health insurance
2 issuer offering a health insurance plan through
3 a plan portal may not—

4 (i) be the private entity developing
5 and maintaining a plan portal under this
6 section; or

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

9 (B) INDIVIDUALS.—An individual em-
10 ployed by a health insurance issuer offering a
11 health insurance plan through a plan portal
12 may not serve as a director or officer for—

13 (i) the private entity developing and
14 maintaining a plan portal under this sec-
15 tion; or

16 (ii) the plan portal.

17 (c) CONSTRUCTION.—Nothing in this section shall be
18 construed to prohibit health insurance brokers and agents
19 from—

20 (1) utilizing the plan portal for any purpose; or

21 (2) marketing or offering health insurance
22 products.

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

1 (e) HEALTH INSURANCE PLANS.—For purposes of
2 this section, the term “health insurance plan” does not
3 include coverage of excepted benefits, as defined in section
4 2791(c) of the Public Health Service Act (42 U.S.C.
5 300gg–91(c)).

6 (f) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated \$50,000,000 for fiscal
8 year 2018 to provide funding for the Secretary of Health
9 and Human Services to award grants to States to enter
10 into contracts to establish a portal plan under this section,
11 to remain available until expended.

12 **Subtitle E—Protecting the Doctor-** 13 **Patient Relationship**

14 **SEC. 441. RULE OF CONSTRUCTION.**

15 Nothing in this Act shall be construed to interfere
16 with the doctor-patient relationship or the practice of med-
17 icine.

18 **SEC. 442. REPEAL OF FEDERAL COORDINATING COUNCIL** 19 **FOR COMPARATIVE EFFECTIVENESS RE-** 20 **SEARCH.**

21 Effective on the date of the enactment of this Act,
22 section 804 of the American Recovery and Reinvestment
23 Act of 2009 (42 U.S.C. 299b–8) is repealed.

1 **Subtitle F—Establishing**
 2 **Association Health Plans**

3 **SEC. 451. RULES GOVERNING ASSOCIATION HEALTH**
 4 **PLANS.**

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

8 **“PART 8—RULES GOVERNING ASSOCIATION**
 9 **HEALTH PLANS**

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

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

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

17 “(1) is organized and maintained in good faith,
 18 with a constitution and bylaws specifically stating its
 19 purpose and providing for periodic meetings on at
 20 least an annual basis, as a bona fide trade associa-
 21 tion, a bona fide industry association (including a
 22 rural electric cooperative association or a rural tele-
 23 phone cooperative association), a bona fide profes-
 24 sional association, or a bona fide chamber of com-
 25 merce (or similar bona fide business association, in-

1 including a corporation or similar organization that
2 operates on a cooperative basis (within the meaning
3 of section 1381 of the Internal Revenue Code of
4 1986)), for substantial purposes other than that of
5 obtaining or providing medical care;

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

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

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

22 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
23 **PLANS.**

24 “(a) IN GENERAL.—The applicable authority shall
25 prescribe by regulation a procedure under which, subject

1 to subsection (b), the applicable authority shall certify as-
2 sociation health plans which apply for certification as
3 meeting the requirements of this part.

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

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

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

23 “(e) CLASS CERTIFICATION FOR FULLY INSURED
24 PLANS.—The applicable authority shall establish a class
25 certification procedure for association health plans under

1 which all benefits consist of health insurance coverage.
2 Under such procedure, the applicable authority shall pro-
3 vide for the granting of certification under this part to
4 the plans in each class of such association health plans
5 upon appropriate filing under such procedure in connec-
6 tion with plans in such class and payment of the pre-
7 scribed fee under section 807(a).

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

13 “(1) a plan which offered such coverage on the
14 date of the enactment of this part,

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

20 “(3) a plan whose eligible participating employ-
21 ers represent one or more trades or businesses, or
22 one or more industries, consisting of any of the fol-
23 lowing: Agriculture; equipment and automobile deal-
24 erships; barbering and cosmetology; certified public
25 accounting practices; child care; construction; dance,

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

15 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
16 **BOARDS OF TRUSTEES.**

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

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

1 “(1) FISCAL CONTROL.—The plan is operated,
2 pursuant to a trust agreement, by a board of trust-
3 ees which has complete fiscal control over the plan
4 and which is responsible for all operations of the
5 plan.

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

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

15 “(A) BOARD MEMBERSHIP.—

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

24 “(ii) LIMITATION.—

1 “(I) GENERAL RULE.—Except as
2 provided in subclauses (II) and (III),
3 no such member is an owner, officer,
4 director, or employee of, or partner in,
5 a contract administrator or other
6 service provider to the plan.

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

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

1 in subclause (I) who is a provider of
2 medical care under the plan.

3 “(iii) CERTAIN PLANS EXCLUDED.—

4 Clause (i) shall not apply to an association
5 health plan which is in existence on the
6 date of the enactment of this part.

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

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

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

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

1 The Secretary may by regulation define for purposes of
2 this subsection the terms ‘franchiser’, ‘franchise network’,
3 and ‘franchisee’.

4 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
5 **MENTS.**

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

10 “(1) each participating employer must be—

11 “(A) a member of the sponsor,

12 “(B) the sponsor, or

13 “(C) an affiliated member of the sponsor

14 with respect to which the requirements of sub-
15 section (b) are met,

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

1 “(2) all individuals commencing coverage under
2 the plan after certification under this part must
3 be—

4 “(A) active or retired owners (including
5 self-employed individuals), officers, directors, or
6 employees of, or partners in, participating em-
7 ployers, or

8 “(B) the beneficiaries of individuals de-
9 scribed in subparagraph (A).

10 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
11 PLOYEES.—In the case of an association health plan in
12 existence on the date of the enactment of this part, an
13 affiliated member of the sponsor of the plan may be of-
14 fered coverage under the plan as a participating employer
15 only if—

16 “(1) the affiliated member was an affiliated
17 member on the date of certification under this part,
18 or

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

1 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
2 quirements of this subsection are met with respect to an
3 association health plan if, under the terms of the plan,
4 no participating employer may provide health insurance
5 coverage in the individual market for any employee not
6 covered under the plan which is similar to the coverage
7 contemporaneously provided to employees of the employer
8 under the plan, if such exclusion of the employee from cov-
9 erage under the plan is based on a health status-related
10 factor with respect to the employee and such employee
11 would, but for such exclusion on such basis, be eligible
12 for coverage under the plan.

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

17 “(1) under the terms of the plan, all employers
18 meeting the preceding requirements of this section
19 are eligible to qualify as participating employers for
20 all geographically available coverage options, unless,
21 in the case of any such employer, participation or
22 contribution requirements of the type referred to in
23 section 2711 of the Public Health Service Act are
24 not met,

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

4 “(3) the applicable requirements of sections
5 701, 702, and 703 are met with respect to the plan.

6 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
7 **DOCUMENTS, CONTRIBUTION RATES, AND**
8 **BENEFIT OPTIONS.**

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

12 “(1) CONTENTS OF GOVERNING INSTRU-
13 MENTS.—The instruments governing the plan in-
14 clude a written instrument, meeting the require-
15 ments of an instrument required under section
16 402(a)(1), which—

17 “(A) provides that the board of trustees
18 serves as the named fiduciary required for plans
19 under section 402(a)(1) and serves in the ca-
20 pacity of a plan administrator (referred to in
21 section 3(16)(A)),

22 “(B) provides that the sponsor of the plan
23 is to serve as plan sponsor (referred to in sec-
24 tion 3(16)(B)), and

1 “(C) incorporates the requirements of sec-
2 tion 806.

3 “(2) CONTRIBUTION RATES MUST BE NON-
4 DISCRIMINATORY.—

5 “(A) The contribution rates for any par-
6 ticipating small employer do not vary on the
7 basis of any health status-related factor in rela-
8 tion to employees of such employer or their
9 beneficiaries and do not vary on the basis of the
10 type of business or industry in which such em-
11 ployer is engaged.

12 “(B) Nothing in this title or any other pro-
13 vision of law shall be construed to preclude an
14 association health plan, or a health insurance
15 issuer offering health insurance coverage in
16 connection with an association health plan,
17 from—

18 “(i) setting contribution rates based
19 on the claims experience of the plan, or

20 “(ii) varying contribution rates for
21 small employers in a State to the extent
22 that such rates could vary using the same
23 methodology employed in such State for
24 regulating premium rates in the small
25 group market with respect to health insur-

1 ance coverage offered in connection with
2 bona fide associations (within the meaning
3 of section 2791(d)(3) of the Public Health
4 Service Act),
5 subject to the requirements of section 702(b)
6 relating to contribution rates.

7 “(3) FLOOR FOR NUMBER OF COVERED INDI-
8 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If
9 any benefit option under the plan does not consist
10 of health insurance coverage, the plan has as of the
11 beginning of the plan year not fewer than 1,000 par-
12 ticipants and beneficiaries.

13 “(4) MARKETING REQUIREMENTS.—

14 “(A) IN GENERAL.—If a benefit option
15 which consists of health insurance coverage is
16 offered under the plan, State-licensed insurance
17 agents shall be used to distribute to small em-
18 ployers coverage which does not consist of
19 health insurance coverage in a manner com-
20 parable to the manner in which such agents are
21 used to distribute health insurance coverage.

22 “(B) STATE-LICENSED INSURANCE
23 AGENTS.—For purposes of subparagraph (A),
24 the term ‘State-licensed insurance agents’
25 means one or more agents who are licensed in

1 a State and are subject to the laws of such
2 State relating to licensure, qualification, test-
3 ing, examination, and continuing education of
4 persons authorized to offer, sell, or solicit
5 health insurance coverage in such State.

6 “(5) REGULATORY REQUIREMENTS.—Such
7 other requirements as the applicable authority deter-
8 mines are necessary to carry out the purposes of this
9 part, which shall be prescribed by the applicable au-
10 thority by regulation.

11 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
12 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
13 nothing in this part or any provision of State law (as de-
14 fined in section 514(e)(1)) shall be construed to preclude
15 an association health plan, or a health insurance issuer
16 offering health insurance coverage in connection with an
17 association health plan, from exercising its sole discretion
18 in selecting the specific items and services consisting of
19 medical care to be included as benefits under such plan
20 or coverage, except (subject to section 514) in the case
21 of (1) any law to the extent that it is not preempted under
22 section 731(a)(1) with respect to matters governed by sec-
23 tion 711, 712, or 713, (2) any law of the State with which
24 filing and approval of a policy type offered by the plan
25 was initially obtained to the extent that such law prohibits

1 an exclusion of a specific disease from such coverage, or
2 (3) any law described in section 601(d) of the American
3 Health Care Reform Act of 2017.

4 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
5 **FOR SOLVENCY FOR PLANS PROVIDING**
6 **HEALTH BENEFITS IN ADDITION TO HEALTH**
7 **INSURANCE COVERAGE.**

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

10 “(1) the benefits under the plan consist solely
11 of health insurance coverage, or

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

15 “(A) establishes and maintains reserves
16 with respect to such additional benefit options,
17 in amounts recommended by the qualified actu-
18 ary, consisting of—

19 “(i) a reserve sufficient for unearned
20 contributions,

21 “(ii) a reserve sufficient for benefit li-
22 abilities which have been incurred, which
23 have not been satisfied, and for which risk
24 of loss has not yet been transferred, and

1 for expected administrative costs with re-
2 spect to such benefit liabilities,

3 “(iii) a reserve sufficient for any other
4 obligations of the plan, and

5 “(iv) a reserve sufficient for a margin
6 of error and other fluctuations, taking into
7 account the specific circumstances of the
8 plan, and

9 “(B) establishes and maintains aggregate
10 and specific excess/stop loss insurance and sol-
11 vency indemnification, with respect to such ad-
12 ditional benefit options for which risk of loss
13 has not yet been transferred, as follows:

14 “(i) The plan shall secure aggregate
15 excess/stop loss insurance for the plan with
16 an attachment point which is not greater
17 than 125 percent of expected gross annual
18 claims. The applicable authority may by
19 regulation provide for upward adjustments
20 in the amount of such percentage in speci-
21 fied circumstances in which the plan spe-
22 cifically provides for and maintains re-
23 serves in excess of the amounts required
24 under subparagraph (A).

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

12 “(iii) The plan shall secure indem-
13 nification insurance for any claims which
14 the plan is unable to satisfy by reason of
15 a plan termination.

16 Any person issuing to a plan insurance described in clause
17 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-
18 retary of any failure of premium payment meriting can-
19 cellation of the policy prior to undertaking such a cancella-
20 tion. Any regulations prescribed by the applicable author-
21 ity pursuant to clause (i) or (ii) of subparagraph (B) may
22 allow for such adjustments in the required levels of excess/
23 stop loss insurance as the qualified actuary may rec-
24 ommend, taking into account the specific circumstances
25 of the plan.

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

6 “(1) \$500,000, or

7 “(2) such greater amount (but not greater than
8 \$2,000,000) as may be set forth in regulations pre-
9 scribed by the applicable authority, considering the
10 level of aggregate and specific excess/stop loss insur-
11 ance provided with respect to such plan and other
12 factors related to solvency risk, such as the plan’s
13 projected levels of participation or claims, the nature
14 of the plan’s liabilities, and the types of assets avail-
15 able to assure that such liabilities are met.

16 “(c) ADDITIONAL REQUIREMENTS.—In the case of
17 any association health plan described in subsection (a)(2),
18 the applicable authority may provide such additional re-
19 quirements relating to reserves, excess/stop loss insurance,
20 and indemnification insurance as the applicable authority
21 considers appropriate. Such requirements may be provided
22 by regulation with respect to any such plan or any class
23 of such plans.

24 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
25 ANCE.—The applicable authority may provide for adjust-

1 ments to the levels of reserves otherwise required under
2 subsections (a) and (b) with respect to any plan or class
3 of plans to take into account excess/stop loss insurance
4 provided with respect to such plan or plans.

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

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

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

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

20 “(B) PENALTIES FOR FAILURE TO MAKE
21 PAYMENTS.—If any payment is not made by a
22 plan when it is due, a late payment charge of
23 not more than 100 percent of the payment
24 which was not timely paid shall be payable by
25 the plan to the Fund.

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

6 “(2) PAYMENTS BY SECRETARY TO CONTINUE
7 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
8 DEMNIFICATION INSURANCE COVERAGE FOR CER-
9 TAIN PLANS.—In any case in which the applicable
10 authority determines that there is, or that there is
11 reason to believe that there will be: (A) A failure to
12 take necessary corrective actions under section
13 809(a) with respect to an association health plan de-
14 scribed in subsection (a)(2); or (B) a termination of
15 such a plan under section 809(b) or 810(b)(8) (and,
16 if the applicable authority is not the Secretary, cer-
17 tifies such determination to the Secretary), the Sec-
18 retary shall determine the amounts necessary to
19 make payments to an insurer (designated by the
20 Secretary) to maintain in force excess/stop loss in-
21 surance coverage or indemnification insurance cov-
22 erage for such plan, if the Secretary determines that
23 there is a reasonable expectation that, without such
24 payments, claims would not be satisfied by reason of
25 termination of such coverage. The Secretary shall, to

1 the extent provided in advance in appropriation
2 Acts, pay such amounts so determined to the insurer
3 designated by the Secretary.

4 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

15 “(B) INVESTMENT.—Whenever the Sec-
16 retary determines that the moneys of the fund
17 are in excess of current needs, the Secretary
18 may request the investment of such amounts as
19 the Secretary determines advisable by the Sec-
20 retary of the Treasury in obligations issued or
21 guaranteed by the United States.

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

24 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
25 ANCE.—The term ‘aggregate excess/stop loss insur-

1 ance’ means, in connection with an association
2 health plan, a contract—

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

9 “(B) which is guaranteed renewable, and

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

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

17 “(A) under which an insurer (meeting such
18 minimum standards as the applicable authority
19 may prescribe by regulation) provides for pay-
20 ment to the plan with respect to claims under
21 the plan in connection with a covered individual
22 in excess of an amount or amounts specified in
23 such contract in connection with such covered
24 individual,

25 “(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 this part, the applicable au-
4 thority shall establish a Solvency Standards Working
5 Group. In prescribing the initial regulations under
6 this section, the applicable authority shall take into
7 account the recommendations of such Working
8 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 actuary, that all applicable require-
7 ments of section 806 are or will be met in ac-
8 cordance with regulations which the applicable
9 authority shall prescribe.

10 “(B) ADEQUACY OF CONTRIBUTION
11 RATES.—A statement of actuarial opinion,
12 signed by a qualified actuary, which sets forth
13 a description of the extent to which contribution
14 rates are adequate to provide for the payment
15 of all obligations and the maintenance of re-
16 quired reserves under the plan for the 12-
17 month period beginning with such date within
18 such 120-day period, taking into account the
19 expected coverage and experience of the plan. If
20 the contribution rates are not fully adequate,
21 the statement of actuarial opinion shall indicate
22 the extent to which the rates are inadequate
23 and the changes needed to ensure adequacy.

24 “(C) CURRENT AND PROJECTED VALUE OF
25 ASSETS AND LIABILITIES.—A statement of ac-

1 tuarial opinion signed by a qualified actuary,
2 which sets forth the current value of the assets
3 and liabilities accumulated under the plan and
4 a projection of the assets, liabilities, income,
5 and expenses of the plan for the 12-month pe-
6 riod referred to in subparagraph (B). The in-
7 come statement shall identify separately the
8 plan’s administrative expenses and claims.

9 “(D) COSTS OF COVERAGE TO BE
10 CHARGED AND OTHER EXPENSES.—A state-
11 ment of the costs of coverage to be charged, in-
12 cluding an itemization of amounts for adminis-
13 tration, reserves, and other expenses associated
14 with the operation of the plan.

15 “(E) OTHER INFORMATION.—Any other
16 information as may be determined by the appli-
17 cable authority, by regulation, as necessary to
18 carry out the purposes of this part.

19 “(c) FILING NOTICE OF CERTIFICATION WITH
20 STATES.—A certification granted under this part to an
21 association health plan shall not be effective unless written
22 notice of such certification is filed with the applicable
23 State authority of each State in which at least 25 percent
24 of the participants and beneficiaries under the plan are
25 located. For purposes of this subsection, an individual

1 shall be considered to be located in the State in which a
2 known address of such individual is located or in which
3 such individual is employed.

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

14 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
15 SOCIATION HEALTH PLANS.—An association health plan
16 certified under this part which provides benefit options in
17 addition to health insurance coverage for such plan year
18 shall meet the requirements of section 103 by filing an
19 annual report under such section which shall include infor-
20 mation described in subsection (b)(6) with respect to the
21 plan year and, notwithstanding section 104(a)(1)(A), shall
22 be filed with the applicable authority not later than 90
23 days after the close of the plan year (or on such later date
24 as may be prescribed by the applicable authority). The ap-

1 plicable authority may require by regulation such interim
2 reports as it considers appropriate.

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

16 “(1) are in the aggregate reasonably related to
17 the experience of the plan and to reasonable expecta-
18 tions, and

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

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

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
2 **MINATION.**

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

9 “(1) provides to the participants and bene-
10 ficiaries a written notice of intent to terminate stat-
11 ing that such termination is intended and the pro-
12 posed termination date,

13 “(2) develops a plan for winding up the affairs
14 of the plan in connection with such termination in
15 a manner which will result in timely payment of all
16 benefits for which the plan is obligated, and

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

19 Actions required under this section shall be taken in such
20 form and manner as may be prescribed by the applicable
21 authority by regulation.

22 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
23 **NATION.**

24 “(a) ACTIONS TO AVOID DEPLETION OF RE-
25 SERVES.—An association health plan which is certified
26 under this part and which provides benefits other than

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

1 “(b) MANDATORY TERMINATION.—In any case in
2 which—

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

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

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

1 possible, wound up in a manner which will result in timely
2 provision of all benefits for which the plan is obligated.

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

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

1 tence of this subsection are remedied or the plan is termi-
2 nated.

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

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

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

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

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

22 “(5) to collect for the plan any amounts due the
23 plan and to recover reasonable expenses of the trust-
24 eeship,

1 “(6) to commence, prosecute, or defend on be-
2 half of the plan any suit or proceeding involving the
3 plan,

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

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

13 “(9) to provide for the enrollment of plan par-
14 ticipants and beneficiaries under appropriate cov-
15 erage options, and

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

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

24 “(1) the sponsor and plan administrator,

25 “(2) each participant,

1 “(3) each participating employer, and

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

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

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

19 “(f) JURISDICTION OF COURT.—

20 “(1) IN GENERAL.—Upon the filing of an appli-
21 cation for the appointment as trustee or the issuance
22 of a decree under this section, the court to which the
23 application is made shall have exclusive jurisdiction
24 of the plan involved and its property wherever lo-
25 cated with the powers, to the extent consistent with

1 the purposes of this section, of a court of the United
2 States having jurisdiction over cases under chapter
3 11 of title 11, United States Code. Pending an adju-
4 dication under this section such court shall stay, and
5 upon appointment by it of the Secretary as trustee,
6 such court shall continue the stay of, any pending
7 mortgage foreclosure, equity receivership, or other
8 proceeding to reorganize, conserve, or liquidate the
9 plan, the sponsor, or property of such plan or spon-
10 sor, and any other suit against any receiver, conser-
11 vator, or trustee of the plan, the sponsor, or prop-
12 erty of the plan or sponsor. Pending such adjudica-
13 tion and upon the appointment by it of the Sec-
14 retary as trustee, the court may stay any proceeding
15 to enforce a lien against property of the plan or the
16 sponsor or any other suit against the plan or the
17 sponsor.

18 “(2) VENUE.—An action under this section
19 may be brought in the judicial district where the
20 sponsor or the plan administrator resides or does
21 business or where any asset of the plan is situated.
22 A district court in which such action is brought may
23 issue process with respect to such action in any
24 other judicial district.

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

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

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

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

17 “(1) such tax is computed by applying a rate to
18 the amount of premiums or contributions, with re-
19 spect to individuals covered under the plan who are
20 residents of such State, which are received by the
21 plan from participating employers located in such
22 State or from such individuals,

23 “(2) the rate of such tax does not exceed the
24 rate of any tax imposed by such State on premiums
25 or contributions received by insurers or health main-

1 tenance organizations for health insurance coverage
2 offered in such State in connection with a group
3 health plan,

4 “(3) such tax is otherwise nondiscriminatory,
5 and

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

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

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

20 “(1) GROUP HEALTH PLAN.—The term ‘group
21 health plan’ has the meaning provided in section
22 733(a)(1) (after applying subsection (b) of this sec-
23 tion).

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

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

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

7 “(5) APPLICABLE AUTHORITY.—The term ‘ap-
8 plicable authority’ means the Secretary, except that,
9 in connection with any exercise of the Secretary’s
10 authority regarding which the Secretary is required
11 under section 506(d) to consult with a State, such
12 term means the Secretary, in consultation with such
13 State.

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

17 “(7) INDIVIDUAL MARKET.—

18 “(A) IN GENERAL.—The term ‘individual
19 market’ means the market for health insurance
20 coverage offered to individuals other than in
21 connection with a group health plan.

22 “(B) TREATMENT OF VERY SMALL
23 GROUPS.—

24 “(i) IN GENERAL.—Subject to clause
25 (ii), such term includes coverage offered in

1 connection with a group health plan that
2 has fewer than 2 participants as current
3 employees or participants described in sec-
4 tion 732(d)(3) on the first day of the plan
5 year.

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

15 “(8) PARTICIPATING EMPLOYER.—The term
16 ‘participating employer’ means, in connection with
17 an association health plan, any employer, if any indi-
18 vidual who is an employee of such employer, a part-
19 ner in such employer, or a self-employed individual
20 who is such employer (or any dependent, as defined
21 under the terms of the plan, of such individual) is
22 or was covered under such plan in connection with
23 the status of such individual as such an employee,
24 partner, or self-employed individual in relation to the
25 plan.

1 “(9) 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 title XXVII of the Public Health Service Act for the
7 State involved with respect to such issuer.

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

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

13 “(A) a person who is otherwise eligible to
14 be a member of the sponsor but who elects an
15 affiliated status with the sponsor,

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

20 “(C) in the case of an association health
21 plan in existence on the date of the enactment
22 of this part, a person eligible to be a member
23 of the sponsor or one of its member associa-
24 tions.

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

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

12 “(b) RULES OF CONSTRUCTION.—

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

20 “(A) in the case of a partnership, the term
21 ‘employer’ (as defined in section 3(5)) includes
22 the partnership in relation to the partners, and
23 the term ‘employee’ (as defined in section 3(6))
24 includes any partner in relation to the partner-
25 ship, and

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

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

19 (b) CONFORMING AMENDMENTS TO PREEMPTION
20 RULES.—

21 (1) Section 514(b)(6) of such Act (29 U.S.C.
22 1144(b)(6)) is amended by adding at the end the
23 following new subparagraph:

24 “(E) The preceding subparagraphs of this paragraph
25 do not apply with respect to any State law in the case

1 of an association health plan which is certified under part
2 8.”.

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

5 (A) in subsection (b)(4), by striking “Sub-
6 section (a)” and inserting “Subsections (a) and
7 (f)”;

8 (B) in subsection (b)(5), by striking “sub-
9 section (a)” in subparagraph (A) and inserting
10 “subsection (a) of this section and subsections
11 (a)(2)(B) and (b) of section 805”, and by strik-
12 ing “subsection (a)” in subparagraph (B) and
13 inserting “subsection (a) of this section or sub-
14 section (a)(2)(B) or (b) of section 805”; and

15 (C) by adding at the end the following new
16 subsection:

17 “(f)(1) Except as provided in subsection (b)(4), the
18 provisions of this title shall supersede any and all State
19 laws insofar as they may now or hereafter preclude, or
20 have the effect of precluding, a health insurance issuer
21 from offering health insurance coverage in connection with
22 an association health plan which is certified under part
23 8.

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

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

13 “(B) In any case in which health insurance cov-
14 erage of any policy type is offered in a State under
15 an association health plan certified under part 8 and
16 the filing, with the applicable State authority (as de-
17 fined in section 812(a)(9)), of the policy form in
18 connection with such policy type is approved by such
19 State authority, the provisions of this title shall su-
20 persede any and all laws of any other State in which
21 health insurance coverage of such type is offered, in-
22 sofar as they may preclude, upon the filing in the
23 same form and manner of such policy form with the
24 applicable State authority in such other State, the
25 approval of the filing in such other State.

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

5 “(A) providing solvency standards or similar
6 standards regarding the adequacy of insurer capital,
7 surplus, reserves, or contributions, or

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

9 “(4) For additional provisions relating to association
10 health plans, see subsections (a)(2)(B) and (b) of section
11 805.

12 “(5) For purposes of this subsection, the term ‘asso-
13 ciation health plan’ has the meaning provided in section
14 801(a), and the terms ‘health insurance coverage’, ‘par-
15 ticipating employer’, and ‘health insurance issuer’ have
16 the meanings provided such terms in section 812, respec-
17 tively.”.

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

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

22 (B) in clause (ii), by inserting “and which
23 does not provide medical care (within the mean-
24 ing of section 733(a)(2)),” after “arrange-

1 ment,” and by striking “title.” and inserting
2 “title, and”; and

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

5 “(iii) subject to subparagraph (E), in the case
6 of any other employee welfare benefit plan which is
7 a multiple employer welfare arrangement and which
8 provides medical care (within the meaning of section
9 733(a)(2)), any law of any State which regulates in-
10 surance may apply.”.

11 (4) Section 514(d) of such Act (29 U.S.C.
12 1144(d)) is amended—

13 (A) by striking “Nothing” and inserting
14 “(1) Except as provided in paragraph (2), noth-
15 ing”; and

16 (B) by adding at the end the following new
17 paragraph:

18 “(2) Nothing in any other provision of law enacted
19 on or after the date of the enactment of this paragraph
20 shall be construed to alter, amend, modify, invalidate, im-
21 pair, or supersede any provision of this title, except by
22 specific cross-reference to the affected section.”.

23 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
24 (29 U.S.C. 102(16)(B)) is amended by adding at the end
25 the following new sentence: “Such term also includes a

1 person serving as the sponsor of an association health plan
2 under part 8.”.

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

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

14 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
15 CATION OF SELF-INSURED ASSOCIATION HEALTH
16 PLANS.—Not later than January 1, 2019, the Secretary
17 of Labor shall report to the Committee on Education and
18 the Workforce of the House of Representatives and the
19 Committee on Health, Education, Labor, and Pensions of
20 the Senate the effect association health plans have had,
21 if any, on reducing the number of uninsured individuals.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “801. Association health plans.
- “802. Certification of association health plans.
- “803. Requirements relating to sponsors and boards of trustees.
- “804. Participation and coverage requirements.
- “805. Other requirements relating to plan documents, contribution rates, and benefit options.
- “806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
- “807. Requirements for application and related requirements.
- “808. Notice requirements for voluntary termination.
- “809. Corrective actions and mandatory termination.
- “810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
- “811. State assessment authority.
- “812. Definitions and rules of construction.”.

1 **SEC. 452. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 2 **PLOYER ARRANGEMENTS.**

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

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

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

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

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

16 (3) by redesignating clauses (iv) and (v) as
17 clauses (v) and (vi), respectively; and

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

20 “(iv) in any case in which the benefit referred
21 to in subparagraph (A) consists of medical care (as
22 defined in section 812(a)(2)), in determining, after
23 the application of clause (i), whether benefits are
24 provided to employees of two or more employers, the
25 arrangement shall be treated as having only one par-

1 participating employer if, after the application of clause
2 (i), the number of individuals who are employees and
3 former employees of any one participating employer
4 and who are covered under the arrangement is
5 greater than 75 percent of the aggregate number of
6 all individuals who are employees or former employ-
7 ees of participating employers and who are covered
8 under the arrangement.”.

9 **SEC. 453. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
10 **CIATION HEALTH PLANS.**

11 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
12 MISREPRESENTATIONS.—Section 501 of the Employee
13 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
14 is amended by adding at the end the following new sub-
15 section:

16 “(c) Any person who willfully falsely represents, to
17 any employee, any employee’s beneficiary, any employer,
18 the Secretary, or any State, a plan or other arrangement
19 established or maintained for the purpose of offering or
20 providing any benefit described in section 3(1) to employ-
21 ees or their beneficiaries as—

22 “(1) being an association health plan which has
23 been certified under part 8,

24 “(2) having been established or maintained
25 under or pursuant to one or more collective bar-

1 gaining agreements which are reached pursuant to
2 collective bargaining described in section 8(d) of the
3 National Labor Relations Act (29 U.S.C. 158(d)) or
4 paragraph Fourth of section 2 of the Railway Labor
5 Act (45 U.S.C. 152, paragraph Fourth) or which are
6 reached pursuant to labor-management negotiations
7 under similar provisions of State public employee re-
8 lations laws, or

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

11 shall, upon conviction, be imprisoned not more than 5
12 years, be fined under title 18, United States Code, or
13 both.”.

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

17 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
18 SIST ORDERS.—

19 “(1) IN GENERAL.—Subject to paragraph (2),
20 upon application by the Secretary showing the oper-
21 ation, promotion, or marketing of an association
22 health plan (or similar arrangement providing bene-
23 fits consisting of medical care (as defined in section
24 733(a)(2))) that—

1 “(A) is not certified under part 8, is sub-
2 ject under section 514(b)(6) to the insurance
3 laws of any State in which the plan or arrange-
4 ment offers or provides benefits, and is not li-
5 censed, registered, or otherwise approved under
6 the insurance laws of such State, or

7 “(B) is an association health plan certified
8 under part 8 and is not operating in accordance
9 with the requirements under part 8 for such
10 certification,

11 a district court of the United States shall enter an
12 order requiring that the plan or arrangement cease
13 activities.

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

18 “(A) all benefits under it referred to in
19 paragraph (1) consist of health insurance cov-
20 erage, and

21 “(B) with respect to each State in which
22 the plan or arrangement offers or provides ben-
23 efits, the plan or arrangement is operating in
24 accordance with applicable State laws that are
25 not superseded under section 514.

1 paragraph (2) with respect to an association health
2 plan regarding the exercise of—

3 “(A) the Secretary’s authority under sec-
4 tions 502 and 504 to enforce the requirements
5 for certification under part 8, and

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

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

16 “(A) in the case of a plan which provides
17 health insurance coverage (as defined in section
18 812(a)(3)), such State shall be the State with
19 which filing and approval of a policy type of-
20 fered by the plan was initially obtained, and

21 “(B) in any other case, the Secretary shall
22 take into account the places of residence of the
23 participants and beneficiaries under the plan
24 and the State in which the trust is main-
25 tained.”.

1 **SEC. 455. EFFECTIVE DATE AND TRANSITIONAL AND**
2 **OTHER RULES.**

3 (a) **EFFECTIVE DATE.**—The amendments made by
4 this subtitle shall take effect 1 year after the date of the
5 enactment of this Act. The Secretary of Labor shall first
6 issue all regulations necessary to carry out the amend-
7 ments made by this subtitle within 1 year after the date
8 of the enactment of this Act.

9 (b) **TREATMENT OF CERTAIN EXISTING HEALTH**
10 **BENEFITS PROGRAMS.**—

11 (1) **IN GENERAL.**—In any case in which, as of
12 the date of the enactment of this Act, an arrange-
13 ment is maintained in a State for the purpose of
14 providing benefits consisting of medical care for the
15 employees and beneficiaries of its participating em-
16 ployers, at least 200 participating employers make
17 contributions to such arrangement, such arrange-
18 ment has been in existence for at least 10 years, and
19 such arrangement is licensed under the laws of one
20 or more States to provide such benefits to its par-
21 ticipating employers, upon the filing with the appli-
22 cable authority (as defined in section 812(a)(5) of
23 the Employee Retirement Income Security Act of
24 1974 (as amended by this subtitle)) by the arrange-
25 ment of an application for certification of the ar-

1 arrangement under part 8 of subtitle B of title I of
2 such Act—

3 (A) such arrangement shall be deemed to
4 be a group health plan for purposes of title I
5 of such Act;

6 (B) the requirements of sections 801(a)
7 and 803(a) of the Employee Retirement Income
8 Security Act of 1974 shall be deemed met with
9 respect to such arrangement;

10 (C) the requirements of section 803(b) of
11 such Act shall be deemed met, if the arrange-
12 ment is operated by a board of directors
13 which—

14 (i) is elected by the participating em-
15 ployers, with each employer having one
16 vote; and

17 (ii) has complete fiscal control over
18 the arrangement and which is responsible
19 for all operations of the arrangement;

20 (D) the requirements of section 804(a) of
21 such Act shall be deemed met with respect to
22 such arrangement; and

23 (E) the arrangement may be certified by
24 any applicable authority with respect to its op-

1 erations in any State only if it operates in such
2 State on the date of certification.

3 The provisions of this subsection shall cease to apply
4 with respect to any such arrangement at such time
5 after the date of the enactment of this Act as the
6 applicable requirements of this subsection are not
7 met with respect to such arrangement.

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

17 **Subtitle G—Greater Choice for**
18 **Veterans**

19 **SEC. 461. REMOVING BARRIERS TO HEALTH CARE CHOICE**
20 **FOR CATEGORY 1 VETERANS AND MEDAL OF**
21 **HONOR RECIPIENTS.**

22 Section 101(b)(2) of the Veterans Access, Choice,
23 and Accountability Act of 2014 (Public Law 113–146; 38
24 U.S.C. 1701 note) is amended—

1 (1) in subparagraph (C)(ii), by striking the
2 “or” at the end;

3 (2) in subparagraph (D)(ii)(II), by striking the
4 period at the end and inserting “; or”; and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 “(E) is a veteran described in section
8 1705(a)(1) of title 38, United States Code, or
9 a veteran who was awarded the medal of honor
10 under section 3741, 6241, or 8741 of title 10
11 or section 491 of title 14.”.

12 **TITLE V—REFORMING MEDICAL** 13 **LIABILITY LAW**

14 **SEC. 501. REQUIREMENTS FOR SELECTION OF CLINICAL** 15 **PRACTICE GUIDELINES.**

16 (a) SELECTION.—Not later than 6 months after the
17 date of enactment of this Act, eligible professional organi-
18 zations that have established, published, maintained, and
19 updated on a regular basis, clinical practice guidelines, in-
20 cluding when applicable, appropriate use criteria, that in-
21 corporate best practices, may submit such guidelines to
22 the Secretary. Not later than 6 months after the last day
23 for submitting such guidelines, the Secretary shall select
24 and designate one or more eligible professional organiza-
25 tions to provide and maintain such clinical practice guide-

1 lines on behalf of the Secretary. Not later than 6 months
2 after designating each such eligible professional organiza-
3 tion, the Secretary shall enter into an agreement with each
4 such eligible professional organization for maintenance,
5 publication, and updating of such clinical practice guide-
6 lines.

7 (b) MAINTENANCE.—

8 (1) PERIODIC REVIEW.—Not later than 5 years
9 the Secretary enters into an agreement with each el-
10 igible professional organization under subsection (a),
11 and every 5 years thereafter, the Secretary shall re-
12 view the clinical practice guidelines of such organiza-
13 tion and shall, as necessary, enter into agreements
14 with additional eligible professional organizations, as
15 appropriate, in accordance with subsection (a).

16 (2) UPDATE BY ELIGIBLE PROFESSIONAL ORGA-
17 NIZATION.—An eligible professional organization
18 that collaborated in the establishment of a clinical
19 practice guidelines may submit amendments to that
20 clinical practice guideline at any time to the Sec-
21 retary for review by the Secretary.

22 (3) NOTIFICATION REQUIRED FOR CERTAIN UP-
23 DATES.—An amendment under paragraph (2) may
24 not add, materially change, or remove a guideline
25 from a set of guidelines, unless notification of such

1 update is made available to applicable eligible profes-
2 sionals.

3 **SEC. 502. DEVELOPMENT.**

4 (a) **GUIDELINE STANDARDS.**—The Secretary shall
5 ensure that, to the extent practicable, the development of
6 clinical practice guidelines are guided by the Standards
7 for Developing Trustworthy Clinical Practice Guidelines of
8 the Institute of Medicine and—

9 (1) are developed through a transparent process
10 that minimizes conflicts of interest;

11 (2) are developed by a knowledgeable, multi-
12 disciplinary panel of experts and representatives
13 from key affected groups;

14 (3) take into consideration important patient
15 subgroups and patient preferences, as appropriate;

16 (4) are based on a systematic review of the ex-
17 isting evidence;

18 (5) provide a clear explanation of the relation-
19 ship between care options and health outcomes;

20 (6) provide ratings of both the quality of evi-
21 dence and strength of recommendation;

22 (7) are reconsidered and revised when new evi-
23 dence emerges; and

24 (8) clearly identify any exceptions to the appli-
25 cation of the clinical practice guideline.

1 (b) REQUIRED DISCLOSURES FROM ELIGIBLE PRO-
2 FESSIONAL ORGANIZATIONS.—Any person who is affili-
3 ated with an eligible professional organization and who di-
4 rectly participated in the creation of a clinical practice
5 guideline shall disclose any conflicts of interest pertaining
6 to the development of the clinical practice guideline, in-
7 cluding any conflict of interest pertaining to any instru-
8 ment, medicine, drug, or any other substance, device, or
9 means included in the clinical practice guideline. Dislo-
10 sures to the Secretary by eligible professional organiza-
11 tions shall be made promptly, upon submission of the
12 guidelines, and during every review of the guidelines. Dis-
13 closures shall include the following:

14 (1) Scientific methodology and evidence that
15 supports clinical practice guidelines.

16 (2) Outside collaborators.

17 (3) Endorsements.

18 **SEC. 503. NO LIABILITY FOR GUIDELINE PRODUCERS.**

19 Neither an eligible professional organization nor the
20 participants in its guideline development and approval
21 process, may be held liable for any injury alleged to be
22 caused by adhering to a clinical practice guideline to which
23 they contributed.

1 **SEC. 504. INTERNET PUBLICATION OF GUIDELINES.**

2 The Secretary shall publish on the Internet through
3 the National Guideline Clearinghouse or other appropriate
4 sites or sources, all clinical practice guidelines, including
5 all data and methodology used in the development and se-
6 lection of the guidelines in compliance with data disclosure
7 standards in the Health Insurance Portability and Ac-
8 countability Act of 1996 (Public Law 104–191).

9 **SEC. 505. STATE FLEXIBILITY AND PROTECTION OF**
10 **STATES' RIGHTS.**

11 (a) **LIMITATION.**—This Act shall not preempt or su-
12 perse any State or Federal law that—

13 (1) imposes procedural or substantive protec-
14 tions for health care providers and health care orga-
15 nizations from liability, loss, or damages greater
16 than such protections provided by this title; or

17 (2) creates a cause of action related to the pro-
18 vision of health care goods or services.

19 (b) **STATE FLEXIBILITY.**—No provision of this Act
20 shall be construed to preempt any defense available to a
21 party in a health care liability action under any other pro-
22 vision of State or Federal law.

23 **SEC. 506. FEDERAL CAUSE OF ACTION.**

24 (a) **IN GENERAL.**—Chapter 85 of title 28, United
25 States Code, is amended by adding at the end the fol-
26 lowing:

1 **“§ 1370. Health care liability claims**

2 “(a) DEFINITIONS.—In this section, the terms ‘appli-
3 cable eligible professional’, ‘health care goods or services’,
4 ‘health care liability action’, ‘health care liability claim’,
5 ‘health care organization’, and ‘health care provider’ have
6 the meaning given such terms in section 10 of the Saving
7 Lives, Saving Costs Act.

8 “(b) JURISDICTION OF CLAIMS.—The district courts
9 shall have original jurisdiction of a health care liability ac-
10 tion against an applicable eligible professional, health care
11 provider, or health care organization.

12 “(c) SUBSTANTIVE LAW.—The substantive law for
13 decision in a health care liability action brought under
14 subsection (b) shall be derived from the law, including
15 choice of law principles, of the State in which the provision
16 of, use of, or payment for (or the failure to provide, use,
17 or pay for) health care goods or services giving rise to
18 the health care liability claim occurred unless such law is
19 inconsistent with or preempted by Federal law.”.

20 (b) TECHNICAL AND CONFORMING AMENDMENT.—
21 The table of sections for chapter 85 of title 28, United
22 States Code, is amended by adding at the end the fol-
23 lowing:

“1370. Health care liability claims.”.

1 **SEC. 507. RIGHT OF REMOVAL.**

2 Section 1441 of title 28, United States Code, is
3 amended by adding at the end the following:

4 “(g) CERTAIN ACTIONS AGAINST MEDICAL PROFES-
5 SIONALS.—(1) A health care liability action brought in a
6 State court against an applicable eligible professional,
7 health care provider, or health care organization may be
8 removed by any defendant or the defendants to the district
9 court of the United States for the district and division em-
10 bracing the place where such action is pending.

11 “(2) In this subsection, the terms ‘applicable eligible
12 professional’, ‘health care liability action’, ‘health care or-
13 ganization’, and ‘health care provider’ have the meaning
14 given such terms in section 10 of the Saving Lives, Saving
15 Costs Act.”.

16 **SEC. 508. MANDATORY REVIEW BY INDEPENDENT MEDICAL**
17 **PANEL.**

18 (a) IN GENERAL.—If, in any health care liability ac-
19 tion removed to Federal court pursuant to section 1441(g)
20 of title 28, United States Code, against an applicable eligi-
21 ble professional, health care provider, or health care orga-
22 nization, the applicable eligible professional, health care
23 provider, or health care organization alleges, in response
24 to a filing of the claimant, that the applicable eligible pro-
25 fessional, health care provider, or health care organization
26 adhered to an applicable clinical practice guideline in the

1 provision of health care goods or services to the claimant,
2 then the court shall suspend further proceedings on the
3 health care liability action prior to discovery proceedings,
4 until the completion of a review of the action by an inde-
5 pendent medical review panel.

6 (b) INDEPENDENT MEDICAL REVIEW PANEL.—

7 (1) COMPOSITION.—An independent medical re-
8 view panel under this section shall be composed of
9 3 members who are experts in the relevant field of
10 clinical practice, appointed in accordance with para-
11 graph (5).

12 (2) REQUIREMENTS FOR MEMBER ELIGI-
13 BILITY.—

14 (A) IN GENERAL.—To be eligible to serve
15 on an independent medical review panel, a
16 member shall—

17 (i) be an experienced physician cer-
18 tified by a board recognized by the Amer-
19 ican Board of Medical Specialties;

20 (ii) not earlier than 2 years prior to
21 the date of selection to the board, have
22 been in active medical practice or devoted
23 a substantial portion of his or her time to
24 teaching at an accredited medical school,
25 or have been engaged in university-based

1 research in relation to the medical care
2 and type of treatment at issue; and

3 (iii) be approved by his or her spe-
4 cialty society.

5 (B) REGIONAL PREFERENCE.—When pos-
6 sible, members should be from the region where
7 the case in question originates to account for
8 geographical practice variation.

9 (3) NO CIVIL LIABILITY FOR MEMBERS.—No
10 civil action shall be brought in any court against any
11 member for any act, failure to act, or statement or
12 opinion made, within the scope of his or her duties
13 as a member of the independent medical review
14 panel.

15 (4) CONSIDERATIONS IN MAKING DETERMINA-
16 TIONS.—The members of the independent medical
17 review panel shall acknowledge that, under certain
18 circumstances, it may be appropriate for a physician
19 to depart from the recommendations in clinical prac-
20 tice guidelines in the care of individual patients.

21 (5) SELECTION OF MEMBERS.—Each member
22 of the independent medical review panel shall be
23 jointly selected by the parties. A member whose se-
24 lection one party does not concur in may not serve
25 on the panel, except that, if, not later than 30 days

1 after a response to the health care liability action is
2 filed, 3 members have not been selected by the par-
3 ties, the court shall appoint any remaining members.

4 (6) COMPENSATION OF MEMBERS.—The costs
5 of compensation to the members of the independent
6 medical review panel shall be shared between the
7 parties equally, unless otherwise agreed to by the
8 parties.

9 (c) TERMS OF REVIEW.—A review by an independent
10 medical review panel under this section shall comply with
11 the following:

12 (1) STANDARD OF CONDUCT.—The mandatory
13 independent medical review panel that is charged
14 with the responsibility of making a preliminary find-
15 ing as to liability of the defendant applicable eligible
16 professional shall deem the prescribed clinical prac-
17 tice guidelines as the standard of conduct, care, and
18 skill expected of members of the medical profession
19 engaged in the defendant's field of practice under
20 the same or similar circumstances, subject to the
21 provisions of subsection (b)(4).

22 (2) RECORD FOR REVIEW.—The independent
23 medical review panel shall make a preliminary find-
24 ing based solely upon the pre-discovery evidence sub-
25 mitted to it pursuant to Rule 26 of the Federal

1 Rules of Civil Procedure, any medical records that
2 would be discoverable if the lawsuit advances to
3 trial, and the applicable prescribed clinical practice
4 guidelines.

5 (3) LIMITATION.—The independent medical re-
6 view panel shall not make a finding of negligence
7 from the mere fact that a treatment or procedure
8 was unsuccessful or failed to bring the best result,
9 or that the patient died.

10 (4) USE AT TRIAL OF WORK PRODUCT OF RE-
11 VIEW PANEL.—No preliminary finding by the inde-
12 pendent medical review panel that the defendant ap-
13 plicable eligible professional breached the standard
14 of care as set forth under the prescribed clinical
15 practice guidelines shall constitute negligence per se
16 or conclusive evidence of liability, but findings, opin-
17 ions, and conclusions of the review panel shall be ad-
18 missible as evidence in any and all subsequent pro-
19 ceedings before the court, including for purposes of
20 motions for summary judgment and at trial.

21 (d) RESULTS OF REVIEW.—

22 (1) IN GENERAL.—Not later than 60 days after
23 all members of the independent medical review panel
24 have been selected, the panel shall complete a review

1 of the record of the liability action and shall make
2 a finding under this subsection.

3 (2) FINDING DESCRIBED.—A finding under this
4 subsection shall include the following:

5 (A) A determination of whether there are
6 any applicable clinical practice guidelines to the
7 health care liability action that substantively
8 pertains to the injury suffered by the claimant.

9 (B) Whether the applicable eligible profes-
10 sional has alleged adherence to any such guide-
11 line.

12 (C) Whether the applicable eligible profes-
13 sional adhered to any such guideline.

14 (D) Whether there is a reasonable prob-
15 ability that—

16 (i) the applicable eligible professional
17 violated the applicable clinical practice
18 guideline;

19 (ii) that violation proximately caused
20 the claimant's alleged injury; and

21 (iii) the claimant suffered damages as
22 a result of the injury.

23 (3) USE AT TRIAL.—The finding under this
24 subsection may be received into evidence by the
25 court. If the independent medical review panel made

1 any finding under paragraph (2)(D) that there was
2 no reasonable probability of the matters described in
3 clauses (i) through (iii), the court may issue a sum-
4 mary judgment in favor of the applicable eligible
5 professional unless the claimant is able to show oth-
6 erwise by clear and convincing evidence. If the panel
7 made a finding under subparagraphs (A) through
8 (C) of paragraph (2) that there was an applicable
9 clinical practice guideline that the defendant adhered
10 to, the court shall issue summary judgment in favor
11 of the applicable eligible professional unless the
12 claimant is able to show otherwise by clear and con-
13 vincing evidence. Any preliminary finding that the
14 defendant applicable eligible professional did not
15 breach the standard of care as set forth under the
16 prescribed medical practice guidelines or that the de-
17 fendant applicable eligible professional's nonadher-
18 ence to the applicable standard was neither the
19 cause in fact nor the proximate cause of the plain-
20 tiff's injury or that the plaintiff did not incur any
21 damages as a result shall be given deference by the
22 court and shall entitle the defendant applicable eligi-
23 ble professional to summary judgment unless the
24 plaintiff is able to show by clear and convincing evi-
25 dence that the independent medical review panel was

1 in error and that there is a genuine issue as to a
2 material fact in the case.

3 **SEC. 509. DEFINITIONS.**

4 In this Act:

5 (1) **APPLICABLE ELIGIBLE PROFESSIONAL.**—

6 The term “applicable eligible professional” means a
7 physician practicing within clinical practice guide-
8 lines submitted by an eligible professional organiza-
9 tion and includes employees and agents of a physi-
10 cian.

11 (2) **APPROPRIATE USE CRITERIA.**—The term

12 “appropriate use criteria” means established evi-
13 dence-based guidelines developed or endorsed by an
14 eligible professional organization that specify when
15 the health benefits of a procedure or service exceed
16 the expected health risks by a significantly wide
17 margin.

18 (3) **CLINICAL PRACTICE GUIDELINE.**—The term

19 “clinical practice guideline” means systematically de-
20 veloped statements based on the review of clinical
21 evidence for assisting a health care provider to de-
22 termine the appropriate health care in specific clin-
23 ical circumstances.

24 (4) **ELIGIBLE PROFESSIONAL ORGANIZATION.**—

25 The term “eligible professional organization” means

1 a national or State medical society or medical spe-
2 cialty society.

3 (5) FEDERAL PAYOR.—The term “Federal
4 payor” includes reimbursements made under the
5 Medicare program under title XVIII of the Social
6 Security Act or the Medicaid program under title
7 XIX of the Social Security Act, or medical
8 screenings, treatments, or transfer services provided
9 pursuant to section 1867 of the Social Security Act
10 is not made by the individual or any non-Federal
11 third party on behalf of the individual.

12 (6) 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 (7) HEALTH CARE LIABILITY ACTION.—The
21 term “health care liability action” means a civil ac-
22 tion against an applicable eligible professional, a
23 health care provider, or a health care organization,
24 regardless of the theory of liability on which the
25 claim is based, or the number of plaintiffs, defend-

1 ants, or other parties, or the number of causes of ac-
2 tion, in which the claimant alleges a health care li-
3 ability claim.

4 (8) HEALTH CARE LIABILITY CLAIM.—The
5 term “health care liability claim” means a claim by
6 any person against an applicable eligible profes-
7 sional, a health care provider, or a health care orga-
8 nization which is based upon the provision of, use of,
9 or payment for (or the failure to provide, use, or pay
10 for) health care goods or services for which at least
11 partial payment was made by a Federal payor or
12 which was mandated by Federal law, regardless of
13 the theory of liability on which the claim is based.

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

21 (10) HEALTH CARE PROVIDER.—The term
22 “health care provider” means any person or entity
23 required by State or Federal laws or regulations to
24 be licensed, registered, or certified to provide health
25 care services, and being either so licensed, reg-

1 istered, or certified, or exempted from such require-
2 ment by other statute or regulation.

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

5 **TITLE VI—OTHER PROVISIONS**

6 **SEC. 601. RESPECTING HUMAN LIFE.**

7 (a) PROHIBITION ON ABORTION MANDATES.—Noth-
8 ing in this Act (or any amendment made by this Act) shall
9 be construed to require any health plan (including any
10 high-risk pool) to provide coverage of, or access to, abor-
11 tion services or to allow the Secretary of the Treasury,
12 the Secretary of Labor, the Secretary of Health and
13 Human Services, or any other Federal or non-Federal per-
14 son or entity in implementing this Act (or an amendment
15 made by this Act) to require coverage of, or access to,
16 abortion services.

17 (b) PROHIBITION ON CERTAIN RESEARCH FUND-
18 ING.—

19 (1) IN GENERAL.—No funds authorized or ap-
20 propriated by this Act (or an amendment made by
21 this Act) may be used to conduct or support re-
22 search that includes embryo-destructive stem cell re-
23 search and human cloning.

24 (2) HUMAN CLONING DEFINED.—In this sub-
25 section, the term “human cloning” means human

1 asexual reproduction accomplished by introducing
2 the nuclear material from a human diploid cell into
3 an oocyte to produce a living organism at any stage
4 of development with a human or predominantly
5 human genetic constitution.

6 (3) CONSTRUCTION.—Nothing in this sub-
7 section may be construed to prohibit conducting or
8 supporting research that does not include embryo-
9 destructive stem cell research or human cloning, in-
10 cluding research involving nuclear transfer or other
11 cloning techniques to produce molecules, DNA, cells
12 other than human embryos, tissues, or animals other
13 than humans.

14 (c) LIMITATION ON ABORTION FUNDING.—

15 (1) IN GENERAL.—No funds authorized or ap-
16 propriated by this Act (or an amendment made by
17 this Act) may be used to pay for any abortion or to
18 cover any part of the costs of any health plan that
19 includes coverage of abortion (including a high-risk
20 pool described in section 2745 of the Public Health
21 Service Act (42 U.S.C. 300gg–45), as amended by
22 section 311 of this Act), except—

23 (A) if the pregnancy is the result of an act
24 of rape or incest; or

1 (B) in the case where a pregnant female
2 suffers from a physical disorder, physical in-
3 jury, or physical illness that would, as certified
4 by a physician, place the female in danger of
5 death unless an abortion is performed, includ-
6 ing a life-endangering physical condition caused
7 by or arising from the pregnancy itself.

8 (2) OPTION TO PURCHASE SEPARATE COV-
9 ERAGE OR PLAN.—Nothing in this subsection shall
10 be construed as prohibiting any non-Federal entity
11 (including an individual or a State or local govern-
12 ment) from purchasing separate coverage for abor-
13 tions for which funding is prohibited under this sub-
14 section, or a health plan that includes such abor-
15 tions, so long as such coverage or plan is paid for
16 entirely using only funds not authorized or appro-
17 priated by this Act.

18 (3) OPTION TO OFFER COVERAGE OR PLAN.—
19 Nothing in this subsection shall restrict any non-
20 Federal health insurance issuer offering a health
21 plan from offering separate coverage for abortions
22 for which funding is prohibited under this sub-
23 section, or a health plan that includes such abor-
24 tions, so long as—

1 (A) premiums for such separate coverage
2 or plan are paid for entirely with funds not au-
3 thorized or appropriated by this Act; and

4 (B) administrative costs and all services
5 offered through such coverage or plan are paid
6 for using only premiums collected for such cov-
7 erage or plan.

8 (4) ADMINISTRATIVE EXPENSES.—No funds
9 authorized or appropriated by this Act shall be avail-
10 able to pay for administrative expenses in connection
11 with any health plan (including an association health
12 plan that has entered into trusteeship) which pro-
13 vides any benefits or coverage for abortions except
14 where the life of the mother would be endangered if
15 the fetus were carried to term, or the pregnancy is
16 the result of an act of rape or incest.

17 (d) NO PREEMPTION OF STATE LAWS.—Nothing in
18 this Act (or an amendment made by this Act) shall be
19 construed to preempt or otherwise have any effect on
20 State laws—

21 (1) protecting conscience rights or restricting or
22 prohibiting abortion or coverage or funding of abor-
23 tion, as in effect on the date of the enactment of this
24 Act; or

1 (2) establishing procedural requirements on
2 abortions, including parental notification or consent
3 for the performance of an abortion on a minor.

4 (e) DEFINITIONS.—In this section:

5 (1) The term “association health plan” has the
6 meaning given to such term in section 801 of the
7 Employee Retirement Income Security Act of 1974,
8 as added by section 451 of this Act.

9 (2) The term “high-risk pool” means a high-
10 risk pool described in section 2745 of the Public
11 Health Service Act (42 U.S.C. 300gg–45), as
12 amended by section 311 of this Act.

13 **SEC. 602. OFFSETS.**

14 Section 251(c) of the Balanced Budget and Emer-
15 gency Deficit Control Act of 1985 (2 U.S.C. 901) is
16 amended as follows:

17 (1) In paragraph (5)(B), by striking the dollar
18 amount and inserting “\$507,300,000,000”.

19 (2) In paragraph (6)(B), by striking the dollar
20 amount and inserting “\$523,700,000,000”.

21 (3) In paragraph (7)(B), by striking the dollar
22 amount and inserting “\$534,900,000,000”.

23 (4) In paragraph (8)(B), by striking the dollar
24 amount and inserting “\$546,700,000,000”.

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