

115TH CONGRESS
1ST SESSION

S. 222

To repeal provisions of the Patient Protection and Affordable Care Act and provide private health insurance reform, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 24, 2017

Mr. PAUL introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To repeal provisions of the Patient Protection and Affordable Care Act and provide private health insurance reform, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Obamacare Replace-
5 ment Act”.

6 **SEC. 2. TABLE OF CONTENTS.**

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

- Sec. 1. Short title.
- Sec. 2. Table of contents.

TITLE I—REPEALS

- Sec. 101. Repeal of individual and employer mandates.

- Sec. 102. Repeal of Public Health Service Act provisions.
- Sec. 103. Repeal of Patient Protection and Affordable Care Act provisions.
- Sec. 104. Conforming and technical amendments.

TITLE II—TAXATION REFORM

Subtitle A—Equalizing Tax Treatment of Non-Employer Provided Health Insurance

- Sec. 201. Tax deduction for health insurance premiums.
- Sec. 202. Refundable tax credit for payroll taxes attributable to health insurance premiums.

Subtitle B—Health Savings Accounts

- Sec. 211. Repeal of contribution limitations.
- Sec. 212. Freedom from mandate.
- Sec. 213. Allowance of distributions for prescription and over-the-counter medicines and drugs.
- Sec. 214. Purchase of health insurance from HSA.
- Sec. 215. Special rule for certain medical expenses incurred before establishment of account.
- Sec. 216. Administrative error correction before due date of return.
- Sec. 217. Allowing HSA rollover to child or parent of account holder.
- Sec. 218. Credit for contributions to an HSA.
- Sec. 219. Equivalent bankruptcy protections for health savings accounts as retirement funds.

Subtitle C—Medical Expenses

- Sec. 221. Certain exercise equipment and physical fitness programs treated as medical care.
- Sec. 222. Certain nutritional and dietary supplements to be treated as medical care.
- Sec. 223. Certain provider fees to be treated as medical care.
- Sec. 224. Clarification of treatment of capitated primary care payments as amounts paid for medical care.

Subtitle D—Miscellaneous

- Sec. 231. Contributions of medicare beneficiaries participating in medicare advantage MSA.
- Sec. 232. Physician charity and uncompensated care deduction.

TITLE III—INDIVIDUAL HEALTH INSURANCE REFORM

- Sec. 301. Pool reform for individual membership expansion.
- Sec. 302. Cooperative governing of individual health insurance coverage.

TITLE IV—ASSOCIATION HEALTH PLANS

- Sec. 401. Rules governing association health plans.
- Sec. 402. Clarification of treatment of single employer arrangements.
- Sec. 403. Enforcement provisions relating to association health plans.
- Sec. 404. Cooperation between Federal and State authorities.
- Sec. 405. Effective date and transitional and other rules.

TITLE V—MEDICAID REFORM

Sec. 501. Increasing State flexibility to conduct Medicaid waivers.

TITLE VI—MISCELLANEOUS PROVISIONS

Sec. 601. Quality health care coalition.

Sec. 602. Certain medical stop-loss insurance obtained by certain plan sponsors of group health plans not included under the definition of health insurance coverage.

1 **TITLE I—REPEALS**

2 **SEC. 101. REPEAL OF INDIVIDUAL AND EMPLOYER MAN-**
3 **DATES.**

4 (a) REPEAL OF INDIVIDUAL MANDATE.—Section
5 5000A of the Internal Revenue Code of 1986 is amended
6 by adding at the end the following:

7 “(h) TERMINATION.—This section shall not apply
8 with respect to any month beginning after the date of en-
9 actment of the Obamacare Replacement Act.”.

10 (b) REPEAL OF EMPLOYER MANDATE.—Section
11 4980H of the Internal Revenue Code of 1986 is amended
12 by adding at the end the following:

13 “(e) TERMINATION.—This section shall not apply
14 with respect to any month beginning after the date of en-
15 actment of the Obamacare Replacement Act.”.

16 **SEC. 102. REPEAL OF PUBLIC HEALTH SERVICE ACT PROVI-**
17 **SIONS.**

18 (a) REPEAL.—The following provisions of title
19 XXVII of the Public Health Service Act (42 U.S.C. 300gg
20 et seq.) are repealed:

21 (1) Section 2701 (42 U.S.C. 300gg).

22 (2) Section 2702 (42 U.S.C. 300gg–1).

- 1 (3) Section 2703 (42 U.S.C. 300gg-2).
- 2 (4) Section 2704 (42 U.S.C. 300gg-3).
- 3 (5) Section 2705 (42 U.S.C. 300gg-4).
- 4 (6) Section 2707 (42 U.S.C. 300gg-6).
- 5 (7) Section 2708 (42 U.S.C. 300gg-7).
- 6 (8) Section 2711 (42 U.S.C. 300gg-11).
- 7 (9) Section 2712 (42 U.S.C. 300gg-12).
- 8 (10) Section 2713 (42 U.S.C. 300gg-13).
- 9 (11) Section 2715 (42 U.S.C. 300gg-15).
- 10 (12) Section 2715A (42 U.S.C. 300gg-15a).
- 11 (13) Section 2716 (42 U.S.C. 300gg-16).
- 12 (14) Section 2718 (42 U.S.C. 300gg-18).
- 13 (15) Section 2719 (42 U.S.C. 300gg-19).
- 14 (16) Section 2719A (42 U.S.C. 300gg-19a).
- 15 (17) Section 2794 (42 U.S.C. 300gg-94), relat-
- 16 ing to ensuring that consumers get value for their
- 17 dollars.

18 (b) REINSTATING PRE-PPACA LAW.—Sections
19 2701, 2702, 2711, and 2712 of the Public Health Service
20 Act as in effect on the day before the date of enactment
21 of the Patient Protection and Affordable Care Act (Public
22 Law 111-148) shall be restored or revived as if such Act
23 had not been enacted (subject to paragraphs (1), (2), (6),
24 and (7) of subsection (c)).

1 (c) REDESIGNATIONS AND TRANSFERS.—The fol-
2 lowing provisions of title XXVII of the Public Health Serv-
3 ice Act (42 U.S.C. 300gg et seq.) shall be redesignated
4 and transferred as follows:

5 (1) Section 2701, as restored or revived under
6 subsection (b), shall be transferred so as to appear
7 as the first section in subpart I of part A.

8 (2) Section 2702, as restored or revived under
9 subsection (b), shall be transferred so as to appear
10 after such section 2701.

11 (3) Section 2706 (42 U.S.C. 300gg–5) shall be
12 redesignated as section 2703 and transferred so as
13 to appear after such section 2702.

14 (4) Section 2709 (42 U.S.C. 300gg–8), relating
15 to coverage for individuals participating in approved
16 clinical trials, shall be redesignated as section 2704
17 and transferred so as to appear after section 2703
18 (as so redesignated).

19 (5) Section 2709 (42 U.S.C. 300gg–9), relating
20 to disclosure of information, shall be redesignated as
21 section 2705 and transferred so as to appear after
22 section 2704 (as so redesignated).

23 (6) Section 2711, as restored or revived under
24 subsection (b), shall be redesignated as section 2706

1 and transferred so as to appear after section 2705
2 (as so redesignated).

3 (7) Section 2712, as restored or revived under
4 subsection (b), shall be redesignated as section 2707
5 and transferred so as to appear after section 2706
6 (as so redesignated).

7 (8) Section 2714 (42 U.S.C. 300gg–14) shall be
8 redesignated as section 2711 and transferred so as
9 to appear as the first section under subpart II of
10 part A.

11 (9) Section 2717 (42 U.S.C. 300gg–17) shall be
12 redesignated as section 2712 and transferred so as
13 to appear after section 2711 (as so redesignated).

14 (d) EFFECTIVE DATES.—

15 (1) IN GENERAL.—Except as provided in para-
16 graph (2), the repeals under subsection (a) shall
17 take effect on the date of enactment of this Act and
18 shall apply to plan years beginning after such date
19 of enactment.

20 (2) DELAYED EFFECTIVE DATES.—The repeals
21 under paragraphs (2), (3), (4), and (5) of subsection
22 (a), the provisions restored or revived under sub-
23 section (b), and the conforming amendment in sec-
24 tion 104(a)(2) shall be effective for plan years begin-
25 ning on January 1, 2019, and (notwithstanding sub-

1 section (c)) the provisions of law repealed by such
2 paragraphs of subsection (a) or amended by such
3 conforming amendment shall continue to remain in
4 effect until such date.

5 **SEC. 103. REPEAL OF PATIENT PROTECTION AND AFFORD-**
6 **ABLE CARE ACT PROVISIONS.**

7 (a) IN GENERAL.—Section 1312(c) of the Patient
8 Protection and Affordable Care Act (42 U.S.C. 18032(c))
9 is repealed.

10 (b) REPEAL OF 3-MONTH GRACE PERIOD FOR NON-
11 PAYMENT PREMIUMS.—Clause (iv) of section
12 1412(c)(2)(B) of the Patient Protection and Affordable
13 Care Act is amended by striking “nonpayment of pre-
14 miums by the insured” and all that follows and inserting
15 “nonpayment of premiums by the insured, notify the Sec-
16 retary of such nonpayment.”.

17 (c) EFFECTIVE DATE.—This section, and the amend-
18 ments made by this section, shall take effect on the date
19 of enactment of this Act and shall apply to plan years and
20 taxable years beginning after such date of enactment.

21 **SEC. 104. CONFORMING AND TECHNICAL AMENDMENTS.**

22 (a) PHSA PROVISIONS.—Title XXVII of the Public
23 Health Service Act (42 U.S.C. 300gg et seq.) is amend-
24 ed—

1 (1) in section 2724(c) (42 U.S.C. 300gg-23(c)),
2 by striking “(other than section 2704)” and insert-
3 ing “(other than section 2725)”;

4 (2) in section 2741(b)(3) (42 U.S.C. 300gg-
5 41(a)(3)), by striking “2712” and inserting “2707”;

6 (3) in section 2751(a) (42 U.S.C. 300gg-
7 51(a)), by striking “2704” and inserting “2725”;

8 (4) in section 2752 (42 U.S.C. 300gg-52), by
9 striking “2706” and inserting “2727”; and

10 (5) in section 2753 (42 U.S.C. 300gg-54), re-
11 lating to coverage of dependent students on medi-
12 cally necessary leave of absence, by striking “2707”
13 and inserting “2728”.

14 (b) PPACA PROVISIONS.—The Patient Protection
15 and Affordable Care Act (Public Law 111-148) is amend-
16 ed—

17 (1) in section 1103(b)(1) (42 U.S.C.
18 18003(b)(1))—

19 (A) by striking “the percentage of total
20 premium revenue expended on nonclinical costs
21 (as reported under section 2718(a) of the Pub-
22 lic Health Service Act),”; and

23 (B) by striking “and be consistent with the
24 standards adopted for the uniform explanation

1 of coverage as provided for in section 2715 of
2 the Public Health Service Act”;

3 (2) in section 1251(a) (42 U.S.C. 18011(a)), by
4 striking paragraphs (3) and (4), and inserting the
5 following:

6 “(3) APPLICATION OF CERTAIN PROVISIONS.—
7 Section 2711 of the Public Health Service Act (re-
8 lating to extension of dependent coverage) shall
9 apply to grandfathered health plans for plan years
10 beginning with the first plan year to which such pro-
11 visions would otherwise apply.”;

12 (3) in section 1301(a)(4) (42 U.S.C.
13 18021(a)(4)), by striking “section 2701(a)(2) of the
14 Public Health Service Act” and inserting “section
15 2701(a)(2) of the Public Health Service Act as in ef-
16 fect on the day before the date of enactment of the
17 Obamacare Replacement Act or as determined by
18 the Secretary”;

19 (4) in section 1302(e)(1)(B)(i) (42 U.S.C.
20 18022(e)(1)(B)(i)), by striking “(except as provided
21 for in section 2713)”;

22 (5) in section 1311 (42 U.S.C. 18031)—

23 (A) in subsection (c)—

24 (i) in paragraph (1)(B), by striking
25 “(in a manner consistent with applicable

1 network adequacy provisions under section
2 2702(c) of the Public Health Service
3 Act)”; and

4 (ii) in paragraph (5), by striking “to
5 the uniform outline of coverage the plan is
6 required to provide under section 2716 of
7 the Public Health Service Act and”;

8 (B) in subsection (d)(4)(E), by striking “,
9 including the use of the uniform outline of cov-
10 erage established under section 2715 of the
11 Public Health Service Act”;

12 (C) in subsection (e)(2), by striking “, and
13 the information and the recommendations” and
14 all that follows through “premium increases,”;
15 and

16 (D) in subsection (f)(2)(B), by inserting
17 before the period “as in effect on the day before
18 the date of enactment of the Obamacare Re-
19 placement Act or as determined by the Sec-
20 retary”;

21 (6) in section 1334(a)(2), by inserting before
22 the period “as in effect on the day before the date
23 of enactment of the Obamacare Replacement Act”.

1 (c) ERISA PROVISIONS.—Section 715 of the Em-
2 ployee Retirement Income Security Act of 1974 (29
3 U.S.C. 1185d) is amended—

4 (1) in subsection (a)—

5 (A) by striking “(a) GENERAL RULE” and
6 all that follows through “the provisions of part
7 A” in paragraph (1) and inserting “The provi-
8 sions of part A”; and

9 (B) by striking “as if included in this sub-
10 part; and” in paragraph (1) and all that follows
11 through “to the extent that” in paragraph (2)
12 and inserting “as if included in this subpart. To
13 the extent that”; and

14 (2) by striking subsection (b).

15 (d) IRC PROVISIONS.—The Internal Revenue Code
16 of 1986 is amended—

17 (1) in section 36B(b)(3)(C)—

18 (A) in the first sentence, by striking “and
19 the premium was adjusted only for the age of
20 each such individual in the manner allowed
21 under section 2701 of the Public Health Service
22 Act”; and

23 (B) by striking the second sentence;

24 (2) in section 833(c), by striking paragraph (5);

25 and

1 (3) in section 9815—

2 (A) in subsection (a)—

3 (i) by striking “(a) GENERAL RULE”
4 and all that follows through “the provi-
5 sions of part A” in paragraph (1) and in-
6 serting “The provisions of part A”; and

7 (ii) by striking “as if included in this
8 subpart; and” in paragraph (1) and all
9 that follows through “to the extent that”
10 in paragraph (2) and inserting “as if in-
11 cluded in this subpart. To the extent
12 that”; and

13 (B) by striking subsection (b).

14 (e) SOCIAL SECURITY ACT.—Section 1937(b)(6)(A)
15 of the Social Security Act (42 U.S.C. 1396u–7(b)(6)(A))
16 is amended by striking “2705(a)” and inserting
17 “2726(a)”.

18 (f) EFFECTIVE DATE.—Except as provided in section
19 102(d)(2), this section and the amendments made by this
20 section shall take effect on the date of enactment of this
21 Act and shall apply to plan years and taxable years begin-
22 ning after such date of enactment.

1 **TITLE II—TAXATION REFORM**
2 **Subtitle A—Equalizing Tax Treat-**
3 **ment of Non-Employer Provided**
4 **Health Insurance**

5 **SEC. 201. TAX DEDUCTION FOR HEALTH INSURANCE PRE-**
6 **MIUMS.**

7 (a) IN GENERAL.—Part VII of subchapter B of chap-
8 ter 1 of the Internal Revenue Code of 1986 is amended
9 by redesignating section 224 as section 225 and by insert-
10 ing after section 222 the following new section:

11 **“SEC. 224. HEALTH INSURANCE PREMIUMS.**

12 “(a) IN GENERAL.—There shall be allowed as a de-
13 duction the amount of premiums paid by the taxpayer for
14 health insurance coverage (as defined in section 9832) of
15 the taxpayer, the taxpayer’s spouse, or any dependent (as
16 defined in section 152, determined without regard to sub-
17 sections (b)(1), (b)(2), and (d)(1)(B) thereof) of the tax-
18 payer.

19 “(b) COORDINATION PROVISIONS.—

20 “(1) PREMIUM ASSISTANCE CREDIT.—Sub-
21 section (a) shall not apply with respect to so much
22 of any premium for which a credit has been allowed
23 under section 36B.

24 “(2) ARCHER MSAS AND HSAS.—Subsection (a)
25 shall not apply with respect to any amount which is

1 treated as a qualified medical expense under either
2 section 220(d) or 223(e).

3 “(3) DEDUCTION FOR MEDICAL EXPENSES.—

4 For purposes of determining the amount of the de-
5 duction under section 213, any amount for which a
6 deduction is allowed under subsection (a) shall not
7 be treated as an expense paid for medical care.”.

8 (b) DEDUCTION AVAILABLE ABOVE THE LINE.—Sec-
9 tion 62(a) of the Internal Revenue Code of 1986 is amend-
10 ed by inserting after paragraph (21) the following new
11 paragraph:

12 “(22) HEALTH INSURANCE PREMIUMS.—The
13 deduction allowed by section 224.”.

14 (c) CONFORMING AMENDMENTS.—

15 (1) Section 35(g)(2) of the Internal Revenue
16 Code of 1986 is amended by striking “or 213” and
17 inserting “213, or 224”.

18 (2) Section 162(l)(3) of such Code is amended
19 by inserting “or 224(a)” after “213(a)”.

20 (3) The table of sections for part VII of sub-
21 chapter B of chapter 1 of such Code is amended by
22 redesignating the item relating to section 224 as re-
23 lating to section 225 and by inserting after the item
24 relating to section 223 the following new item:

“Sec. 224. Health insurance premiums.”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2016.

4 **SEC. 202. REFUNDABLE TAX CREDIT FOR PAYROLL TAXES**
5 **ATTRIBUTABLE TO HEALTH INSURANCE PRE-**
6 **MIUMS.**

7 (a) IN GENERAL.—Subpart C of part IV of sub-
8 chapter A of chapter 1 of the Internal Revenue Code of
9 1986 is amended by adding at the end the following new
10 section:

11 **“SEC. 36C. REFUND OF PAYROLL TAXES ATTRIBUTABLE TO**
12 **HEALTH INSURANCE PREMIUMS.**

13 “(a) ALLOWANCE OF CREDIT.—There shall be al-
14 lowed as a credit against the tax imposed by this subtitle
15 for any taxable year an amount equal to the applicable
16 percentage of the premiums paid by the taxpayer for
17 health insurance coverage (as defined in section 9832) of
18 the taxpayer, the taxpayer’s spouse, or any dependent (as
19 defined in section 152, determined without regard to sub-
20 sections (b)(1), (b)(2), and (d)(1)(B) thereof) of the tax-
21 payer.

22 “(b) APPLICABLE PERCENTAGE.—For purposes of
23 subsection (a), the term ‘applicable percentage’ means the
24 percentage equal to the sum of the rates of in effect under
25 subsections (a) and (b) of section 3101.

1 “(c) LIMITATION.—The amount of the credit allowed
2 under subsection (a) shall not exceed the excess of—

3 “(1) the social security taxes (as defined in sec-
4 tion 24(d)) of the taxpayer for the taxable year, re-
5 duced by

6 “(2) the sum of the credits allowed under sec-
7 tion 24(d) and 32 for the taxable year.”.

8 (b) CONFORMING AMENDMENTS.—

9 (1) Paragraph (2) of section 1324(b) of title
10 31, United States Code, is amended by inserting “,
11 36C” after “36B”.

12 (2) The table of sections for subpart C of part
13 IV of subchapter A of chapter 1 of the Internal Rev-
14 enue Code of 1986 is amended by inserting after the
15 item relating to section 36B the following new item:

“Sec. 36C. Refund of payroll taxes attributable to health insurance pre-
miums.”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 December 31, 2016.

19 **Subtitle B—Health Savings** 20 **Accounts**

21 **SEC. 211. REPEAL OF CONTRIBUTION LIMITATIONS.**

22 (a) IN GENERAL.—Subsection (b) of section 223 of
23 the Internal Revenue Code of 1986 is amended to read
24 as follows:

1 “(b) DENIAL OF DEDUCTION TO DEPENDENTS.—No
2 deduction shall be allowed under this section to any indi-
3 vidual with respect to whom a deduction under section 151
4 is allowable to another taxpayer for a taxable year begin-
5 ning in the calendar year in which such individual’s tax-
6 able year begins.”.

7 (b) CONFORMING AMENDMENTS.—

8 (1) Subparagraph (A) of section 223(d)(1) of
9 the Internal Revenue Code of 1986 is amended—

10 (A) by striking “subsection (f)(5)” and in-
11 serting “subsection (f)(4)”, and

12 (B) by striking “accepted—” and all that
13 follows and inserting “accepted unless it is in
14 cash.”.

15 (2) Subsection (f) of section 223 of such Code
16 is amended by striking paragraph (3) and by redesi-
17 gnating paragraphs (4) through (8) as paragraphs
18 (3) through (7), respectively.

19 (3) Subsection (g) of section 223 of such Code
20 is amended—

21 (A) by striking “subsections (b)(2) and
22 (c)(2)(A)” both places it appears and inserting
23 “subsection (c)(2)(A)”, and

24 (B) by amending subparagraph (B) to read
25 as follows:

1 “(B) the cost-of-living adjustment deter-
2 mined under section 1(f)(3) for the calendar
3 year in which such taxable year begins deter-
4 mined by substituting ‘calendar year 2003’ for
5 ‘calendar year 1992’.”.

6 (4) Section 26(b)(2) of such Code is amended—

7 (A) by striking “, 223(b)(8)(B)(i)(II),” in
8 subparagraph (S), and

9 (B) by striking “223(f)(4)” in subpara-
10 graph (U) and inserting “223(f)(3)”.

11 (5) Paragraph (1) of section 106(d) of such
12 Code is amended by striking “under an accident or
13 health plan” and all that follows and inserting
14 “under an accident or health plan.”.

15 (6) Subparagraph (C) of section 106(e)(4) of
16 such Code is amended by striking “223(f)(5)” and
17 inserting “223(f)(4)”.

18 (7) Subparagraph (C) of section 408(d)(9) of
19 such Code is amended—

20 (A) by striking “LIMITATIONS.—” in the
21 heading and all that follows through “(ii) ONE-
22 TIME TRANSFER.—” in clause (ii), and insert-
23 ing “ONE-TIME TRANSFER.—”,

1 (B) by redesignating subclauses (I) and
2 (II) as clauses (i) and (ii) and moving such
3 clauses 2 ems to the left, and

4 (C) by striking “subclause (II)” in clause
5 (i), as so redesignated, and inserting “clause
6 (ii)”.

7 (8) Section 4973 of such Code is amended by
8 striking subsection (g) and by redesignating sub-
9 section (h) as subsection (g).

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

13 **SEC. 212. FREEDOM FROM MANDATE.**

14 (a) IN GENERAL.—Section 223 of the Internal Rev-
15 enue Code of 1986, as amended by section 211, is further
16 amended by striking subsections (c) and (g) and by red-
17 ignating subsections (d), (e), (f), and (h) as subsections
18 (c), (d), (e), and (f), respectively.

19 (b) CONFORMING AMENDMENTS.—

20 (1) Subsection (a) of section 223 of the Inter-
21 nal Revenue Code of 1986 is amended to read as fol-
22 lows:

23 “(a) DEDUCTION ALLOWED.—In the case of an indi-
24 vidual, there shall be allowed as a deduction for the tax-
25 able year an amount equal to the aggregate amount paid

1 in cash during such taxable year by or on behalf of such
2 individual to a health savings account of such individual.”.

3 (2) Subsection (c)(1)(A) of section 223 of such
4 Code, as amended by section 211 and redesignated
5 by subsection (a), is further amended by striking
6 “subsection (f)(4)” and inserting “subsection
7 (e)(4)”.

8 (3) Subparagraph (U) of section 26(b)(2) of
9 such Code, as amended by section 211, is further
10 amended by striking “section 223(f)(3)” and insert-
11 ing “section 223(e)(3)”.

12 (4) Sections 35(g)(3), 220(f)(5)(A),
13 848(e)(1)(B)(v), 4973(a)(5), and 6051(a)(12) of
14 such Code are each amended by striking “section
15 223(d)” each place it appears and inserting “section
16 223(c)”.

17 (5) Section 106(d)(1) of such Code is amend-
18 ed—

19 (A) by striking “who is an eligible indi-
20 vidual (as defined in section 223(c)(1))”, and

21 (B) by striking “section 223(d)” and in-
22 serting “section 223(c)”.

23 (6) Section 106(e) of such Code is amended—

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

4 (B) by inserting after paragraph (2) the
5 following new paragraph:

6 “(3) TREATMENT AS ROLLOVER CONTRIBU-
7 TION.—A qualified HSA distribution shall be treated
8 as a rollover contribution described in section
9 223(e)(4).”, and

10 (C) by striking “to any eligible individual
11 covered under a high deductible health plan of
12 the employer” in paragraph (4)(B)(ii) (as so re-
13 designated) and inserting “to any employee
14 with respect to whom a health savings account
15 has been established”.

16 (7) Section 408(d)(9)(A) of such Code is
17 amended by striking “who is an eligible individual
18 (as defined in section 223(e)) and”.

19 (8) Section 877A(g)(6) of such Code is amend-
20 ed by striking “223(f)(4)” and inserting
21 “223(e)(4)”.

22 (9) Section 4975 of such Code is amended—

23 (A) in subsection (c)(6)—

24 (i) by striking “section 223(d)” and
25 inserting “section 223(c)”, and

1 (ii) by striking “section 223(e)(2)”
 2 and inserting “section 223(d)(2)”, and
 3 (B) in subsection (e)(1)(E), by striking
 4 “section 223(d)” and inserting “section
 5 223(c)”.

6 (10) Subsection (b) of section 4980G of such
 7 Code is amended to read as follows:

8 “(b) RULES AND REQUIREMENTS.—

9 “(1) IN GENERAL.—An employer meets the re-
 10 quirements of this subsection for any calendar year
 11 if the employer makes available comparable con-
 12 tributions to the health savings accounts of all com-
 13 parable participating employees for each coverage
 14 period during such calendar year.

15 “(2) COMPARABLE CONTRIBUTIONS.—

16 “(A) IN GENERAL.—For purposes of para-
 17 graph (1), the term ‘comparable contributions’
 18 means contributions—

19 “(i) which are the same amount, or

20 “(ii) if the employees are covered by a
 21 health plan, which are the same percentage
 22 of the annual deductible limit under the
 23 plan covering the employees.

24 “(B) PART-YEAR EMPLOYEES.—In the
 25 case of an employee who is employed by the em-

1 employer for only a portion of the calendar year,
2 a contribution to the health savings account of
3 such employee shall be treated as comparable if
4 it is an amount which bears the same ratio to
5 the comparable amount (determined without re-
6 gard to this subparagraph) as such portion
7 bears to the entire calendar year.

8 “(3) COMPARABLE PARTICIPATING EMPLOY-
9 EES.—For purposes of paragraph (1), the term
10 ‘comparable participating employees’ means all em-
11 ployees who are covered (if at all) under the same
12 health plan of the employer and have the same cat-
13 egory of coverage. For purposes of the preceding
14 sentence, the categories of coverage are self-only and
15 family coverage.

16 “(4) PART-TIME EMPLOYEES.—

17 “(A) IN GENERAL.—Paragraph (3) shall
18 be applied separately with respect to part-time
19 employees and other employees.

20 “(B) PART-TIME EMPLOYEE.—For pur-
21 poses of subparagraph (A), the term ‘part-time
22 employee’ means any employee who is custom-
23 arily employed for fewer than 30 hours per
24 week.”.

1 (11) Section 4980G(d) of such Code is amended
2 by striking “section 4980E” and inserting “this sec-
3 tion”.

4 (12) Section 6693(a)(2)(C) of such Code is
5 amended by striking “section 223(h)” and inserting
6 “section 223(f)”.

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

10 **SEC. 213. ALLOWANCE OF DISTRIBUTIONS FOR PRESCRIP-**
11 **TION AND OVER-THE-COUNTER MEDICINES**
12 **AND DRUGS.**

13 (a) HSAS.—Paragraph (2)(A) of section 223(c) of
14 the Internal Revenue Code of 1986, as redesignated by
15 section 212, is amended by striking the last sentence
16 thereof and inserting the following: “Such term shall in-
17 clude an amount paid for any prescription or over-the-
18 counter medicine or drug.”.

19 (b) ARCHER MSAS.—Section 220(d)(2)(A) of the In-
20 ternal Revenue Code of 1986 is amended by striking the
21 last sentence thereof and inserting the following: “Such
22 term shall include an amount paid for any prescription
23 or over-the-counter medicine or drug.”.

24 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
25 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sub-

1 section (f) of section 106 of the Internal Revenue Code
2 of 1986 is amended to read as follows:

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

8 (d) EFFECTIVE DATES.—

9 (1) DISTRIBUTIONS FROM SAVINGS AC-
10 COUNTS.—The amendments made by subsections (a)
11 and (b) shall apply to amounts paid in taxable years
12 beginning after the date of the enactment of this
13 Act.

14 (2) REIMBURSEMENTS.—The amendment made
15 by subsection (c) shall apply to expenses incurred in
16 plan years beginning after the date of the enactment
17 of this Act.

18 **SEC. 214. PURCHASE OF HEALTH INSURANCE FROM HSA.**

19 (a) IN GENERAL.—Paragraph (2) of section 223(c)
20 of the Internal Revenue Code of 1986, as redesignated by
21 section 212, is amended by striking subparagraphs (B)
22 and (C).

23 (b) CONFORMING AMENDMENT.—Paragraph (2) of
24 section 223(c) of the Internal Revenue Code of 1986, as
25 amended by the preceding sections of this subtitle, is fur-

1 ther amended by striking “and any dependent (as defined
 2 in section 152, determined without regard to subsections
 3 (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual”
 4 and inserting “any dependent (as defined in section 152,
 5 determined without regard to subsections (b)(1), (b)(2),
 6 and (d)(1)(B) thereof) of such individual, and any child
 7 (as defined in section 152(f)(1)) of such individual who
 8 has not attained the age of 27 before the end of such indi-
 9 vidual’s taxable year”.

10 (c) EFFECTIVE DATE.—The amendments 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 such date.

14 **SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**
 15 **INCURRED BEFORE ESTABLISHMENT OF AC-**
 16 **COUNT.**

17 (a) IN GENERAL.—Paragraph (2) of section 223(c)
 18 of the Internal Revenue Code of 1986, as amended and
 19 redesignated by the preceding sections of this subtitle, is
 20 further amended by adding at the end the following new
 21 subparagraph:

22 “(B) CERTAIN MEDICAL EXPENSES IN-
 23 CURRED BEFORE ESTABLISHMENT OF ACCOUNT
 24 TREATED AS QUALIFIED.—An expense shall not
 25 fail to be treated as a qualified medical expense

1 solely because such expense was incurred before
2 the establishment of the health savings account
3 if such expense was incurred—

4 “(i) during either—

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

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

16 “(ii) for medical care which (but for
17 the fact that it was incurred before the es-
18 tablishment of the account) otherwise
19 meets the requirements of the preceding
20 subparagraphs.”.

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

1 **SEC. 216. ADMINISTRATIVE ERROR CORRECTION BEFORE**
2 **DUE DATE OF RETURN.**

3 (a) IN GENERAL.—Paragraph (3) of section 223(f)
4 of the Internal Revenue Code of 1986, as in effect on the
5 day before the date of the enactment of this Act, is amend-
6 ed by adding at the end the following new subparagraph:

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

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

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

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

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

1 **SEC. 217. ALLOWING HSA ROLLOVER TO CHILD OR PARENT**
2 **OF ACCOUNT HOLDER.**

3 (a) **IN GENERAL.**—Paragraph (7)(A) of section
4 223(e) of the Internal Revenue Code of 1986, as redesign-
5 nated by the preceding sections of this subtitle, is amend-
6 ed—

7 (1) by inserting “, child, parent, or grand-
8 parent” after “surviving spouse”,

9 (2) by inserting “, child, parent, or grand-
10 parent, as the case may be,” after “the spouse”,

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

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

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

1 **SEC. 218. CREDIT FOR CONTRIBUTIONS TO AN HSA.**

2 (a) IN GENERAL.—Subpart A of part IV of sub-
3 chapter A of chapter 1 of the Internal Revenue Code of
4 1986 is amended by inserting after section 25D the fol-
5 lowing new section:

6 **“SEC. 25E. CONTRIBUTIONS TO A HEALTH SAVINGS AC-
7 COUNT.**

8 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
9 dividual, there shall be allowed as a credit against the tax
10 imposed by this subtitle for the taxable year an amount
11 equal to so much of the qualified HSA contributions of
12 the individual as does not exceed \$5,000 (\$10,000 in the
13 case of a joint return).

14 “(b) QUALIFIED HSA CONTRIBUTION.—

15 “(1) IN GENERAL.—For purposes of this sec-
16 tion, the term ‘qualified HSA contribution’ means
17 an amount paid in cash during the taxable year by
18 or on behalf of an individual to a health savings ac-
19 count (as defined in section 223(c)) of such indi-
20 vidual.

21 “(2) EXCEPTION FOR AMOUNTS NOT USED FOR
22 QUALIFIED MEDICAL EXPENSES.—The amount
23 taken into account as qualified HSA contributions of
24 the individual under paragraph (1) for a taxable
25 year shall be reduced by the amount of any distribu-
26 tion from such health savings account during such

1 taxable year which is not used exclusively to pay the
2 qualified medical expenses of the account beneficiary
3 (within the meaning of section 223(e)(2)).

4 “(c) COORDINATION WITH DEDUCTION.—For co-
5 ordination rule, see section 223(b)(1).”.

6 (b) CLERICAL AMENDMENT.—The table of sections
7 for subpart A of part IV of subchapter A of chapter 1
8 of the Internal Revenue Code of 1986 is amended by in-
9 serting after the item relating to section 25D the following
10 new item:

“Sec. 25E. Contributions to a health savings account.”.

11 (c) CONFORMING AMENDMENT.—Subsection (b) of
12 section 223 of the Internal Revenue Code of 1986, as
13 amended by section 211, is further amended to read as
14 follows:

15 “(b) SPECIAL RULES.—

16 “(1) COORDINATION WITH CREDIT.—The
17 amount taken into account under subsection (a) with
18 respect to any individual shall be reduced (but not
19 below zero) by the amount of any credit allowed
20 under section 25E for qualified HSA contributions
21 with respect to the individual.

22 “(2) DENIAL OF DEDUCTION TO DEPEND-
23 ENTS.—No deduction shall be allowed under this
24 section to any individual with respect to whom a de-
25 duction under section 151 is allowable to another

1 taxpayer for a taxable year beginning in the cal-
2 endar year in which such individual's taxable year
3 begins.”.

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

7 **SEC. 219. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**
8 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**
9 **MENT FUNDS.**

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

13 “(r) TREATMENT OF HEALTH SAVINGS AC-
14 COUNTS.—For purposes of this section, any health savings
15 account (as described in section 223 of the Internal Rev-
16 enue Code of 1986) shall be treated in the same manner
17 as an individual retirement account described in section
18 408 of such Code.”.

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

1 **Subtitle C—Medical Expenses**

2 **SEC. 221. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL** 3 **FITNESS PROGRAMS TREATED AS MEDICAL** 4 **CARE.**

5 (a) IN GENERAL.—Subsection (d) of section 213 of
6 the Internal Revenue Code of 1986 is amended by adding
7 at the end the following new paragraph:

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

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

12 “(i) for equipment for use in a pro-
13 gram (including a self-directed program) of
14 physical exercise or physical activity,

15 “(ii) to participate, or receive instruc-
16 tion, in a program of physical exercise, nu-
17 trition, or health coaching (including a
18 self-directed program), and

19 “(iii) for membership at a fitness fa-
20 cility.

21 “(B) OVERALL DOLLAR LIMITATION.—

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

1 “(ii) EXCEPTION.—Clause (i) shall
2 not apply for purposes of determining
3 whether expenses reimbursed through a
4 health flexible spending arrangement sub-
5 ject to section 125(i)(1) are incurred for
6 medical care.

7 “(C) LIMITATIONS RELATED TO SPORTS
8 AND FITNESS EQUIPMENT.—Amounts paid for
9 equipment described in subparagraph (A)(i)
10 shall be treated as medical care only—

11 “(i) if such equipment is utilized ex-
12 clusively for participation in fitness, exer-
13 cise, sport, or other physical activity pro-
14 grams,

15 “(ii) if such equipment is not apparel
16 or footwear, and

17 “(iii) in the case of any item of sports
18 equipment (other than exercise equip-
19 ment), to the extent the amount paid for
20 such item does not exceed \$250.

21 “(D) FITNESS FACILITY.—For purposes of
22 subparagraph (A)(iii), the term ‘fitness facility’
23 means a facility—

24 “(i) which provides instruction in a
25 program of physical exercise, offers facili-

1 ties for the preservation, maintenance, en-
 2 couragement, or development of physical
 3 fitness, or serves as the site of such a pro-
 4 gram of a State or local government,

5 “(ii) which is not a private club owned
 6 and operated by its members,

7 “(iii) which does not offer golf, hunt-
 8 ing, sailing, or riding facilities,

9 “(iv) whose health or fitness facility is
 10 not incidental to its overall function and
 11 purpose, and

12 “(v) which is fully compliant with the
 13 State of jurisdiction and Federal anti-dis-
 14 crimination laws.”.

15 (b) LIMITATION NOT TO APPLY FOR CERTAIN PUR-

16 POSES.—

17 (1) HEALTH SAVINGS ACCOUNTS.—Subpara-
 18 graph (A) of section 223(c)(2) of the Internal Rev-
 19 enue Code of 1986, as amended and redesignated by
 20 subtitle B, is further amended by inserting “, deter-
 21 mined without regard to paragraph (12)(B) there-
 22 of)” after “medical care (as defined in section
 23 213(d)”.

24 (2) ARCHER MSAS.—Subparagraph (A) of sec-
 25 tion 220(d)(2) of the Internal Revenue Code of

1 1986, as amended by subtitle B, is further amended
2 by inserting “, determined without regard to para-
3 graph (12)(B) thereof” after “medical care (as de-
4 fined in section 213(d)”.

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

8 **SEC. 222. CERTAIN NUTRITIONAL AND DIETARY SUPPLE-**
9 **MENTS TO BE TREATED AS MEDICAL CARE.**

10 (a) IN GENERAL.—Subsection (d) of section 213 of
11 the Internal Revenue Code of 1986, as amended by section
12 221, is further amended by adding at the end the following
13 new paragraph:

14 “(13) NUTRITIONAL AND DIETARY SUPPLE-
15 MENTS.—

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

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

1 “(C) MEAL REPLACEMENT PRODUCT.—

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

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

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

12 “(D) EXCEPTION.—Subparagraph (B)
13 shall not apply for purposes of determining
14 whether expenses reimbursed through a health
15 flexible spending arrangement subject to section
16 125(i)(1) are incurred for medical care.”.

17 (b) LIMITATION NOT TO APPLY FOR CERTAIN PUR-
18 POSES.—

19 (1) HEALTH SAVINGS ACCOUNTS.—Subpara-
20 graph (A) of section 223(e)(2) of the Internal Rev-
21 enue Code of 1986, as amended and redesignated by
22 this Act, is amended by striking “paragraph
23 (12)(B)” and inserting “paragraphs (12)(B) and
24 (13)(B)”.

1 (2) ARCHER MSAS.—Subparagraph (A) of sec-
2 tion 220(d)(2), as amended by this Act, is amended
3 by striking “paragraph (12)(B)” and inserting
4 “paragraphs (12)(B) and (13)(B)”.

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

8 **SEC. 223. CERTAIN PROVIDER FEES TO BE TREATED AS**
9 **MEDICAL CARE.**

10 (a) IN GENERAL.—Subsection (d) of section 213 of
11 the Internal Revenue Code of 1986, as amended by sec-
12 tions 221 and 222, is amended by adding at the end the
13 following new paragraph:

14 “(14) PERIODIC PROVIDER FEES.—The term
15 ‘medical care’ shall include—

16 “(A) periodic fees paid to a primary care
17 physician for a defined set of medical services
18 or the right to receive medical services on an
19 as-needed basis, and

20 “(B) pre-paid primary care services de-
21 signed to screen for, diagnose, cure, mitigate,
22 treat, or prevent disease and promote
23 wellness.”.

24 (b) EXCEPTION FOR FLEXIBLE SPENDING AC-
25 COUNTS.—Section 125 of the Internal Revenue Code of

1 1986 is amended by redesignating subsections (k) and (l)
2 as subsections (l) and (m), respectively, and by inserting
3 after subsection (j) the following new subsection:

4 “(k) SPECIAL RULE WITH RESPECT TO HEALTH
5 FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of
6 applying this section with respect to any health flexible
7 spending arrangement, amounts described in section
8 213(d)(14) shall not be considered insurance.”.

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

12 **SEC. 224. CLARIFICATION OF TREATMENT OF CAPITATED**
13 **PRIMARY CARE PAYMENTS AS AMOUNTS**
14 **PAID FOR MEDICAL CARE.**

15 (a) IN GENERAL.—Subsection (d) of section 213 of
16 the Internal Revenue Code of 1986, as amended by the
17 preceding provisions of this Act, is amended by adding at
18 the end the following new paragraph:

19 “(15) TREATMENT OF CAPITATED PRIMARY
20 CARE PAYMENTS.—Capitated primary care payments
21 shall be treated as amounts paid for medical care.”.

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

1 **Subtitle D—Miscellaneous**

2 **SEC. 231. CONTRIBUTIONS OF MEDICARE BENEFICIARIES**

3 **PARTICIPATING IN MEDICARE ADVANTAGE**

4 **MSA.**

5 (a) **IN GENERAL.**—Section 138(b) of the Internal
6 Revenue Code of 1986 is amended by striking paragraph
7 (2) and by redesignating paragraphs (3) and (4) as para-
8 graphs (2) and (3), respectively.

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. 232. PHYSICIAN CHARITY AND UNCOMPENSATED**

13 **CARE DEDUCTION.**

14 (a) **IN GENERAL.**—Part VI of subchapter B of chap-
15 ter 1 of the Internal Revenue Code of 1986 is amended
16 by adding at the end the following new section:

17 **“SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED**

18 **CARE.**

19 “(a) **IN GENERAL.**—In the case of a physician, there
20 shall be allowed as a deduction for the taxable year an
21 amount equal to the sum of—

22 “(1) the amount such physician would have oth-
23 erwise charged for qualified charity care provided by
24 such physician during such taxable year, and

1 “(2) the amount of any debt owed to such phy-
2 sician for physicians’ services which becomes worth-
3 less during such taxable year.

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

5 “(1) PHYSICIAN.—The term ‘physician’ has the
6 meaning given to such term in section 1861(r) of the
7 Social Security Act (42 U.S.C. 1395x(r)).

8 “(2) QUALIFIED CHARITY CARE.—The term
9 ‘qualified charity care’ means physicians’ services
10 provided on a volunteer or pro bono basis (not in-
11 cluding any services for which an amount was
12 charged but not paid).

13 “(3) PHYSICIANS’ SERVICES.—The term ‘physi-
14 cians’ services’ has the meaning given such term in
15 section 1861(q) of the Social Security Act (42
16 U.S.C. 1395x(q)).

17 “(c) LIMITATIONS.—

18 “(1) SERVICE CHARGE LIMITATION.—The
19 amount determined under subsection (a) with re-
20 spect to any services or debt—

21 “(A) shall be reduced by any reimburse-
22 ment received by the physician for such services
23 or debt, and

24 “(B) shall not exceed the economic index
25 referred to in the fourth sentence of section

1 1842(b)(3) of the Social Security Act (42
2 U.S.C. 1395u(b)(3)) applicable to the qualified
3 charity care provided or the services provided
4 with respect to which the debt relates.

5 In the case of physicians' services to which such eco-
6 nomic index is not applicable, the Secretary, in con-
7 sultation with the Secretary of Health and Human
8 Services, shall use data on uncompensated care for
9 purposes of the limitation under subparagraph (B),
10 and may adjust such data so as to be an appropriate
11 proxy, including (in the case of qualified charity
12 care) a downward adjustment to eliminate bad debt
13 data from uncompensated care data.

14 “(2) OVERALL LIMITATION.—The amount al-
15 lowed as a deduction under subsection (a) for any
16 taxable year shall not exceed an amount equal to 10
17 percent of the gross income of the taxpayer for the
18 taxable year derived from the taxpayer's provision of
19 physicians' services.

20 “(d) DENIAL OF DOUBLE BENEFIT.—No deduction
21 shall be allowed under section 166 or any other provision
22 of this title for the amount of any bad debt taken into
23 account under subsection (a)(2) (as reduced, if applicable,
24 under subsection (c)).”.

1 (b) CLERICAL AMENDMENT.—The table of sections
 2 for part VI of subchapter B of chapter 1 of the Internal
 3 Revenue Code of 1986 is amended by adding at the end
 4 the following new item:

“Sec. 199A. Physician charity and uncompensated care.”.

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

8 **TITLE III—INDIVIDUAL HEALTH**
 9 **INSURANCE REFORM**

10 **SEC. 301. POOL REFORM FOR INDIVIDUAL MEMBERSHIP**
 11 **EXPANSION.**

12 The Public Health Service Act is amended by insert-
 13 ing after title XXXIII the following new title:

14 **“TITLE XXXIV—POOL REFORM**
 15 **FOR INDIVIDUAL MEMBER-**
 16 **SHIP EXPANSION**

17 **“SEC. 3400. PURPOSE.**

18 “The purpose of this title is to provide, through the
 19 establishment of independent health pools (referred to in
 20 this title as ‘IHP’), for the reform of, and expansion of
 21 enrollment in, health insurance coverage for individuals
 22 and small employers.

1 **“SEC. 3401. DEFINITION OF INDEPENDENT HEALTH POOL.**

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

5 “(1) ORGANIZATION.—The IHP—

6 “(A) has been formed and maintained in
7 good faith for a purpose that includes the for-
8 mation of a risk pool in order to offer health in-
9 surance coverage to its members;

10 “(B) does not condition membership in the
11 IHP on any health status-related factor relating
12 to an individual (including an employee of an
13 employer or a dependent of an employee);

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

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

18 “(E) does not receive any consideration di-
19 rectly or indirectly from any health insurance
20 issuer in connection with the enrollment of any
21 individuals, or employees of employers, in any
22 health insurance coverage, except in conjunction
23 with services offered through the IHP.

24 “(2) OFFERING HEALTH BENEFITS COV-
25 ERAGE.—

1 “(A) DIFFERENT GROUPS.—The IHP, in
2 conjunction with those health insurance issuers
3 that offer health benefits coverage through the
4 IHP, makes available health benefits coverage
5 in the manner described in subsection (b) to all
6 members of the IHP and the dependents of
7 such members (and, in the case of small em-
8 ployers, employees and their dependents) in the
9 manner described in subsection (c)(2) at rates
10 that are established by the health insurance
11 issuer on a policy or product specific basis and
12 that may vary for individuals covered through
13 an IHP.

14 “(B) NONDISCRIMINATION IN COVERAGE
15 OFFERED.—

16 “(i) IN GENERAL.—Subject to clause
17 (ii), the IHP may not offer health benefits
18 coverage to a member of an IHP unless
19 the same coverage is offered to all such
20 members of the IHP.

21 “(ii) CONSTRUCTION.—Nothing in
22 this title shall be construed as requiring or
23 permitting a health insurance issuer to
24 provide coverage outside the service area of
25 the issuer, as approved under State law, or

1 preventing a health insurance issuer from
2 underwriting or from excluding or limiting
3 the coverage on any individual, subject to
4 the requirement of section 2741 (relating
5 to guaranteed availability of individual
6 health insurance coverage to certain indi-
7 viduals with prior group coverage).

8 “(C) NO ASSUMPTION OF INSURANCE RISK
9 BY IHP.—The IHP provides health benefits cov-
10 erage only through contracts with health insur-
11 ance issuers and does not assume insurance
12 risk with respect to such coverage.

13 “(3) GEOGRAPHIC AREAS.—Nothing in this title
14 shall be construed as preventing the establishment
15 and operation of more than one IHP in a geographic
16 area or as limiting the number of IHPs that may
17 operate in any area.

18 “(4) PROVISION OF ADMINISTRATIVE SERVICES
19 TO PURCHASERS.—The IHP may provide adminis-
20 trative services for members. Such services may in-
21 clude accounting, billing, and enrollment informa-
22 tion.

23 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
24 MENTS.—

1 “(1) COMPLIANCE WITH CONSUMER PROTEC-
2 TION REQUIREMENTS.—Except as provided in sec-
3 tion 3402, any health benefits coverage offered
4 through an IHP—

5 “(A) shall be issued by a health insurance
6 issuer that meets all applicable State standards
7 relating to consumer protection;

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

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

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

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

25 “(1) MEMBERS.—

1 “(A) IN GENERAL.—Under rules estab-
2 lished to carry out this title, with respect to an
3 individual or small employer who is a member
4 of an IHP, the individual may enroll for health
5 benefits coverage (including coverage for de-
6 pendents of such individual) or the employer
7 may enroll employees for health benefits cov-
8 erage (including coverage for dependents of
9 such employees) offered by a health insurance
10 issuer through the IHP.

11 “(B) RULES FOR ENROLLMENT.—Nothing
12 in this paragraph shall preclude an IHP from
13 establishing rules of enrollment and reenroll-
14 ment of members. Such rules shall be applied
15 consistently to all members within the IHP and
16 shall not be based in any manner on health sta-
17 tus-related factors.

18 “(2) HEALTH INSURANCE ISSUERS.—The con-
19 tract between an IHP and a health insurance issuer
20 shall provide, with respect to a member enrolled with
21 health benefits coverage offered by the issuer
22 through the IHP, for the payment to the issuer of
23 the premiums (if any) collected by the IHP for
24 health insurance coverage offered by the issuer.

1 **“SEC. 3402. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
 2 **MENTS.**

3 “(a) PREEMPTION OF STATE LAWS RESTRICTING
 4 FORMATION OF IHPs.—Any State law or regulation relat-
 5 ing to the composition or organization of an IHP is pre-
 6 empted to the extent the law or regulation is inconsistent
 7 with the provisions of this title.

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

10 “(1) BENEFIT REQUIREMENTS.—

11 “(A) IN GENERAL.—Subject to subpara-
 12 graph (B), State laws are superseded, and shall
 13 not apply to health benefits coverage made
 14 available through an IHP, insofar as such laws
 15 impose benefit requirements for such coverage,
 16 including requirements relating to coverage of
 17 specific providers, specific services or condi-
 18 tions, or the amount, duration, or scope of ben-
 19 efits.

20 “(B) EXCEPTION FOR FEDERALLY IM-
 21 POSED REQUIREMENTS AND FOR REQUIRE-
 22 MENTS PROHIBITING DISEASE-SPECIFIC EXCLU-
 23 SIONS.—Subparagraph (A) shall not apply to a
 24 requirement to the extent the requirement—

25 “(i) implements title XXVII or other
 26 Federal law; or

1 “(ii) prohibits imposition of an exclu-
2 sion of a specific disease from health bene-
3 fits coverage.

4 “(2) OTHER REQUIREMENTS PREVENTING OF-
5 FERING OF COVERAGE THROUGH AN IHP.—State
6 laws are superseded, and shall not apply to health
7 benefits coverage made available through an IHP,
8 insofar as such laws impose any other requirements
9 (including limitations on compensation arrange-
10 ments) that, directly or indirectly, preclude (or have
11 the effect of precluding) the offering of such cov-
12 erage through an IHP, if the IHP meets the re-
13 quirements of this title.

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

20 **“SEC. 3403. DEFINITIONS.**

21 “For purposes of this title:

22 “(1) DEPENDENT.—The term ‘dependent’, as
23 applied to health insurance coverage offered by a
24 health insurance issuer licensed (or otherwise regu-
25 lated) in a State, shall have the meaning applied to

1 such term with respect to such coverage under the
2 laws of the State relating to such coverage and such
3 an issuer. Such term may include the spouse and
4 children of the individual involved.

5 “(2) HEALTH BENEFITS COVERAGE.—The term
6 ‘health benefits coverage’ has the meaning given the
7 term ‘health insurance coverage’ in section
8 2791(b)(1), and does not include excepted benefits
9 (as defined in section 2791(c)).

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

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

16 “(5) MEMBER.—The term ‘member’ means,
17 with respect to an IHP, an individual or small em-
18 ployer who is a member of the legal entity described
19 in section 3401(a)(1) to which the IHP is offering
20 coverage.

21 “(6) SMALL EMPLOYER.—The term ‘small em-
22 ployer’ has the meaning given such term in section
23 712(c)(1)(B) of the Employee Retirement Income
24 Security Act of 1974.”

1 **SEC. 302. COOPERATIVE GOVERNING OF INDIVIDUAL**
 2 **HEALTH INSURANCE COVERAGE.**

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

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

8 **“SEC. 2795. DEFINITIONS.**

9 “In this part:

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

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

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

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

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

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

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

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

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

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

9 “(7) COVERED LAWS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 “NOTICE

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

1 strictions on rate changes of the _____. As with all
2 insurance products, before purchasing this policy, you
3 should carefully review the policy and determine what
4 health care services the policy covers and what benefits
5 it provides, including any exclusions, limitations, or condi-
6 tions for such services or benefits.’.

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

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

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

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

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

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

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

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

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

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

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

22 “(D) from reinstating lapsed coverage; or

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

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

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

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

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

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

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

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

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

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

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

21 “(B) a qualified loss reserve specialist.

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

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

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

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

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

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

23 “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

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

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

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

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

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

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

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

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

21 “(2) in any case in which the requirements of
22 paragraph (1) are not met with respect to the either
23 of such States, the issuer provides an independent
24 review mechanism substantially identical (as deter-
25 mined by the applicable State authority of such
26 State) to that prescribed in the ‘Health Carrier Ex-

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

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

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

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

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

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

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

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

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

11 “(3) INDEPENDENCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **“SEC. 2799. ENFORCEMENT.**

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

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

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

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

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

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

7 (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

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

8 **SEC. 401. RULES GOVERNING ASSOCIATION HEALTH**
 9 **PLANS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(e) CLASS CERTIFICATION FOR FULLY INSURED
6 PLANS.—The applicable authority shall establish a class
7 certification procedure for association health plans under
8 which all benefits consist of health insurance coverage.
9 Under such procedure, the applicable authority shall pro-
10 vide for the granting of certification under this part to
11 the plans in each class of such association health plans
12 upon appropriate filing under such procedure in connec-
13 tion with plans in such class and payment of the pre-
14 scribed fee under section 807(a).

15 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
16 HEALTH PLANS.—An association health plan which offers
17 one or more benefit options which do not consist of health
18 insurance coverage may be certified under this part only
19 if such plan consists of—

20 “(1) a plan which offered such coverage on the
21 date of the enactment of the Obamacare Replace-
22 ment Act;

23 “(2) a plan under which the sponsor does not
24 restrict membership to one or more trades and busi-
25 nesses or industries and whose eligible participating

1 employers represent a broad cross-section of trades
2 and businesses or industries; or

3 “(3) a plan whose eligible participating employ-
4 ers represent one or more trades or businesses, or
5 one or more industries, consisting of any of the fol-
6 lowing: agriculture; equipment and automobile deal-
7 erships; barbering and cosmetology; certified public
8 accounting practices; child care; construction; dance,
9 theatrical and orchestra productions; disinfecting
10 and pest control; financial services; fishing; food
11 service establishments; hospitals; labor organiza-
12 tions; logging; manufacturing (metals); mining; med-
13 ical and dental practices; medical laboratories; pro-
14 fessional consulting services; sanitary services; trans-
15 portation (local and freight); warehousing; whole-
16 saling/distributing; or any other trade or business or
17 industry which has been indicated as having average
18 or above-average risk or health claims experience by
19 reason of State rate filings, denials of coverage, pro-
20 posed premium rate levels, or other means dem-
21 onstrated by such plan in accordance with regula-
22 tions.

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

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

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

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

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

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

26 “(A) BOARD MEMBERSHIP.—

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

9 “(ii) LIMITATION.—

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

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

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

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

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

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

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

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

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

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

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

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

20 “(1) each participating employer must be—

21 “(A) a member of the sponsor;

22 “(B) the sponsor; or

23 “(C) an affiliated member of the sponsor
24 with respect to which the requirements of sub-
25 section (b) are met,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 “(1) \$500,000; or

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(3) ASSOCIATION HEALTH PLAN FUND.—

11 “(A) IN GENERAL.—There is established in
12 the Treasury a fund to be known as the ‘Asso-
13 ciation Health Plan Fund’. The Fund shall be
14 available for making payments pursuant to
15 paragraph (2). The Fund shall be credited with
16 payments received pursuant to paragraph
17 (1)(A), penalties received pursuant to para-
18 graph (1)(B), and earnings on investments of
19 amounts of the Fund under subparagraph (B).

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

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

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

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

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

15 “(B) which is guaranteed renewable; and

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

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

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

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

6 “(B) which is guaranteed renewable; and

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

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

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

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

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

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

7 “(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

21 “(A) A representative of the National As-
22 sociation of Insurance Commissioners.

23 “(B) A representative of the American
24 Academy of Actuaries.

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

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

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

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

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

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

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

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

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

5 “(A) the sponsor; and

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

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

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

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

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

1 plan and contract administrators and other service
2 providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
5 **NATION.**

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

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

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

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

22 “(2) the applicable authority determines that
23 there is a reasonable expectation that the plan will
24 continue to fail to meet the requirements of section
25 806,

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

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

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

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

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

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

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

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

24 “(4) to require the sponsor, the plan adminis-
25 trator, any participating employer, and any employee

1 organization representing plan participants to fur-
2 nish any information with respect to the plan which
3 the Secretary as trustee may reasonably need in
4 order to administer the plan;

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

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

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

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

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

23 “(10) to do such other acts as may be nec-
24 essary to comply with this title or any order of the
25 court and to protect the interests of plan partici-

1 pants and beneficiaries and providers of medical
2 care.

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

6 “(1) the sponsor and plan administrator;

7 “(2) each participant;

8 “(3) each participating employer; and

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

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

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

1 “(f) JURISDICTION OF COURT.—

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

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

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

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

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

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

24 “(1) such tax is computed by applying a rate to
25 the amount of premiums or contributions, with re-

1 spect to individuals covered under the plan who are
2 residents of such State, which are received by the
3 plan from participating employers located in such
4 State or from such individuals;

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

11 “(3) such tax is otherwise nondiscriminatory;
12 and

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

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

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

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

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

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

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

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

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

25 “(7) INDIVIDUAL MARKET.—

1 “(A) IN GENERAL.—The term ‘individual
2 market’ means the market for health insurance
3 coverage offered to individuals other than in
4 connection with a group health plan.

5 “(B) TREATMENT OF VERY SMALL
6 GROUPS.—

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

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

23 “(8) PARTICIPATING EMPLOYER.—The term
24 ‘participating employer’ means, in connection with
25 an association health plan, any employer, if any indi-

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

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

16 “(10) QUALIFIED HEALTH ACTUARY.—The
 17 term ‘qualified health actuary’ means an individual
 18 who is a member of the American Academy of Actu-
 19 aries with expertise in health care.

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

22 “(A) a person who is otherwise eligible to
 23 be a member of the sponsor but who elects an
 24 affiliated status with the sponsor,

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

5 “(C) in the case of an association health
6 plan in existence on the date of the enactment
7 of the Obamacare Replacement Act, a person
8 eligible to be a member of the sponsor or one
9 of its member associations.

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

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

21 “(b) RULES OF CONSTRUCTION.—

22 “(1) EMPLOYERS AND EMPLOYEES.—For pur-
23 poses of determining whether a plan, fund, or pro-
24 gram is an employee welfare benefit plan which is an
25 association health plan, and for purposes of applying

1 this title in connection with such plan, fund, or pro-
2 gram so determined to be such an employee welfare
3 benefit plan—

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

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

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

1 employee welfare benefit plan on and after the date
2 of such demonstration.

3 “(3) EXCEPTION FOR CERTAIN BENEFITS.—

4 The requirements of this part shall not apply to a
5 group health plan in relation to its provision of ex-
6 cepted benefits, as defined in section 733(c).”.

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

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

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

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

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

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

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

3 (C) by redesignating subsection (d) as sub-
4 section (e); and

5 (D) by inserting after subsection (c) the
6 following new subsection:

7 “(d)(1) Except as provided in subsection (b)(4), the
8 provisions of this title shall supersede any and all State
9 laws insofar as they may now or hereafter preclude, or
10 have the effect of precluding, a health insurance issuer
11 from offering health insurance coverage in connection with
12 an association health plan which is certified under part
13 8.

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

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

1 such other employers are participating employers in
2 such plan.

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

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

20 “(A) providing solvency standards or similar
21 standards regarding the adequacy of insurer capital,
22 surplus, reserves, or contributions, or

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

1 “(4) For additional provisions relating to association
2 health plans, see subsections (a)(2)(B) and (b) of section
3 805.

4 “(5) For purposes of this subsection, the term ‘asso-
5 ciation health plan’ has the meaning provided in section
6 801(a), and the terms ‘health insurance coverage’, ‘par-
7 ticipating employer’, and ‘health insurance issuer’ have
8 the meanings provided such terms in section 812, respec-
9 tively.”.

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

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

14 (B) in clause (ii)—

15 (i) by inserting “and which does not
16 provide medical care (within the meaning
17 of section 733(a)(2)),” after “arrange-
18 ment,”; and

19 (ii) by striking “title.” and inserting
20 “title, and”; and

21 (C) by adding at the end the following new
22 clause:

23 “(iii) subject to subparagraph (E), in the case
24 of any other employee welfare benefit plan which is
25 a multiple employer welfare arrangement and which

1 provides medical care (within the meaning of section
2 733(a)(2)), any law of any State which regulates in-
3 surance may apply.”.

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

6 (A) by striking “Nothing” and inserting
7 “(1) Except as provided in paragraph (2), noth-
8 ing”; and

9 (B) by adding at the end the following new
10 paragraph:

11 “(2) Nothing in any other provision of law enacted
12 on or after the date of the enactment of the Obamacare
13 Replacement Act shall be construed to alter, amend, mod-
14 ify, invalidate, impair, or supersede any provision of this
15 title, except by specific cross-reference to the affected sec-
16 tion.”.

17 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
18 (29 U.S.C. 102(16)(B)) is amended by adding at the end
19 the following new sentence: “Such term also includes a
20 person serving as the sponsor of an association health plan
21 under part 8 of subtitle B.”.

22 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
23 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
24 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)
25 of such Act (29 U.S.C. 1022(b)) is amended by adding

1 at the end the following: “An association health plan shall
 2 include in its summary plan description, in connection
 3 with each benefit option, a description of the form of sol-
 4 vency or guarantee fund protection secured pursuant to
 5 this Act or applicable State law, if any.”.

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

8 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
 9 CATION OF SELF-INSURED ASSOCIATION HEALTH
 10 PLANS.—Not later than January 1, 2018, the Secretary
 11 of Labor shall report to the Committee on Education and
 12 the Workforce of the House of Representatives and the
 13 Committee on Health, Education, Labor, and Pensions of
 14 the Senate the effect association health plans have had,
 15 if any, on reducing the number of uninsured individuals.

16 (g) CLERICAL AMENDMENT.—The table of contents
 17 in section 1 of the Employee Retirement Income Security
 18 Act of 1974 is amended by inserting after the item relat-
 19 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. 402. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 2 **PLOYER ARRANGEMENTS.**

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

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

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

19 “(iii)(I) in any case in which the benefit re-
 20 ferred to in subparagraph (A) consists of medical
 21 care (as defined in section 812(a)(2)), the deter-
 22 mination of whether a trade or business is under
 23 ‘common control’ with another trade or business

1 shall be determined under regulations of the Sec-
2 retary applying principles consistent and coextensive
3 with the principles applied in determining whether
4 employees of two or more trades or businesses are
5 treated as employed by a single employer under sec-
6 tion 4001(b), except that, for purposes of this para-
7 graph, an interest of greater than 25 percent may
8 not be required as the minimum interest necessary
9 for common control, or

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

11 (3) by redesignating clauses (iv) and (v) as
12 clauses (v) and (vi), respectively; and

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

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

1 all individuals who are employees or former employ-
2 ees of participating employers and who are covered
3 under the arrangement,”.

4 **SEC. 403. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
5 **CIATION HEALTH PLANS.**

6 (a) **CRIMINAL PENALTIES FOR CERTAIN WILLFUL**
7 **MISREPRESENTATIONS.**—Section 501 of the Employee
8 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
9 is amended by adding at the end the following new sub-
10 section:

11 “(c) Any person who willfully falsely represents, to
12 any employee, any employee’s beneficiary, any employer,
13 the Secretary, or any State, a plan or other arrangement
14 established or maintained for the purpose of offering or
15 providing any benefit described in section 3(1) to employ-
16 ees or their beneficiaries as—

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

19 “(2) having been established or maintained
20 under or pursuant to one or more collective bar-
21 gaining agreements which are reached pursuant to
22 collective bargaining described in section 8(d) of the
23 National Labor Relations Act (29 U.S.C. 158(d)) or
24 paragraph Fourth of section 2 of the Railway Labor
25 Act (45 U.S.C. 152, paragraph Fourth) or which are

1 reached pursuant to labor-management negotiations
2 under similar provisions of State public employee re-
3 lations laws; or

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

6 shall, upon conviction, be imprisoned not more than 5
7 years, be fined under title 18, United States Code, or
8 both.”.

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

12 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
13 SIST ORDERS.—

14 “(1) IN GENERAL.—Subject to paragraph (2),
15 upon application by the Secretary showing the oper-
16 ation, promotion, or marketing of an association
17 health plan (or similar arrangement providing bene-
18 fits consisting of medical care (as defined in section
19 733(a)(2))) that—

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

1 “(B) is an association health plan certified
2 under part 8 and is not operating in accordance
3 with the requirements under part 8 for such
4 certification,

5 a district court of the United States shall enter an
6 order requiring that the plan or arrangement cease
7 activities.

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

12 “(A) all benefits under it referred to in
13 paragraph (1) consist of health insurance cov-
14 erage; and

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

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

1 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—

2 Section 503 of such Act (29 U.S.C. 1133) is amended—

3 (1) by inserting “(a) IN GENERAL.—” before

4 “In accordance”; and

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

6 section:

7 “(b) ASSOCIATION HEALTH PLANS.—The terms of
8 each association health plan which is or has been certified
9 under part 8 shall require the board of trustees or the
10 named fiduciary (as applicable) to ensure that the require-
11 ments of this section are met in connection with claims
12 filed under the plan.”.

13 **SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE**
14 **AUTHORITIES.**

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

18 “(d) CONSULTATION WITH STATES WITH RESPECT
19 TO ASSOCIATION HEALTH PLANS.—

20 “(1) AGREEMENTS WITH STATES.—The Sec-
21 retary shall consult with the State recognized under
22 paragraph (2) with respect to an association health
23 plan regarding the exercise of—

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

4 “(B) the Secretary’s authority to certify
5 association health plans under part 8 in accord-
6 ance with regulations of the Secretary applica-
7 ble to certification under part 8.

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

14 “(A) in the case of a plan which provides
15 health insurance coverage (as defined in section
16 812(a)(3)), such State shall be the State with
17 which filing and approval of a policy type of-
18 fered by the plan was initially obtained; and

19 “(B) in any other case, the Secretary shall
20 take into account the places of residence of the
21 participants and beneficiaries under the plan
22 and the State in which the trust is main-
23 tained.”.

1 **SEC. 405. 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 subsection (a)(8) of such sec-
14 tion to an “association health plan” shall be deemed
15 a reference to an arrangement referred to in this
16 subsection.

17 **TITLE V—MEDICAID REFORM**

18 **SEC. 501. INCREASING STATE FLEXIBILITY TO CONDUCT**

19 **MEDICAID WAIVERS.**

20 Section 1115(a)(1) of the Social Security Act (42
21 U.S.C. 1315(a)(1)) is amended—

22 (1) by striking “1602, or 1902” and inserting
23 “or 1602”; and

24 (2) by inserting “and shall waive compliance
25 with section 1902,” after “as the case may be,”.

1 **TITLE VI—MISCELLANEOUS**
2 **PROVISIONS**

3 **SEC. 601. QUALITY HEALTH CARE COALITION.**

4 (a) APPLICATION OF THE FEDERAL ANTITRUST
5 LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING
6 WITH HEALTH PLANS.—

7 (1) IN GENERAL.—Any health care profes-
8 sionals who are engaged in negotiations with a
9 health plan regarding the terms of any contract
10 under which the professionals provide health care
11 items or services for which benefits are provided
12 under such plan shall, in connection with such nego-
13 tiations, be exempt from the Federal antitrust laws.

14 (2) LIMITATION.—

15 (A) NO NEW RIGHT FOR COLLECTIVE CES-
16 SATION OF SERVICE.—The exemption provided
17 in paragraph (1) shall not confer any new right
18 to participate in any collective cessation of serv-
19 ice to patients not already permitted by existing
20 law.

21 (B) NO CHANGE IN NATIONAL LABOR RE-
22 LATIONS ACT.—This section applies only to
23 health care professionals excluded from the Na-
24 tional Labor Relations Act (29 U.S.C. 151 et
25 seq.). Nothing in this section shall be construed

1 as changing or amending any provision of the
2 National Labor Relations Act, or as affecting
3 the status of any group of persons under that
4 Act.

5 (3) NO APPLICATION TO FEDERAL PRO-
6 GRAMS.—Nothing in this section shall apply to nego-
7 tiations between health care professionals and health
8 plans pertaining to benefits provided under any of
9 the following:

10 (A) The Medicare program under title
11 XVIII of the Social Security Act (42 U.S.C.
12 1395 et seq.).

13 (B) The Medicaid program under title XIX
14 of the Social Security Act (42 U.S.C. 1396 et
15 seq.).

16 (C) The State Children’s Health Insurance
17 Program under title XXI of the Social Security
18 Act (42 U.S.C. 1397aa et seq.).

19 (D) Chapter 55 of title 10, United States
20 Code (relating to medical and dental care for
21 members of the uniformed services).

22 (E) Chapter 17 of title 38, United States
23 Code (relating to Veterans’ medical care).

1 (F) Chapter 89 of title 5, United States
2 Code (relating to the Federal Employees Health
3 Benefits program).

4 (G) The Indian Health Care Improvement
5 Act (25 U.S.C. 1601 et seq.).

6 (b) DEFINITIONS.—In this section, the following defi-
7 nitions shall apply:

8 (1) ANTITRUST LAWS.—The term “antitrust
9 laws”—

10 (A) has the meaning given it in subsection
11 (a) of the first section of the Clayton Act (15
12 U.S.C. 12(a)), except that such term includes
13 section 5 of the Federal Trade Commission Act
14 (15 U.S.C. 45) to the extent such section ap-
15 plies to unfair methods of competition; and

16 (B) includes any State law similar to the
17 laws referred to in subparagraph (A).

18 (2) GROUP HEALTH PLAN.—The term “group
19 health plan” means an employee welfare benefit plan
20 to the extent that the plan provides medical care (in-
21 cluding items and services paid for as medical care)
22 to employees or their dependents (as defined under
23 the terms of the plan) directly or through insurance,
24 reimbursement, or otherwise.

1 (3) GROUP HEALTH PLAN, HEALTH INSURANCE
2 ISSUER.—The terms “group health plan” and
3 “health insurance issuer” include a third-party ad-
4 ministrators or other person acting for or on behalf
5 of such plan or issuer.

6 (4) HEALTH CARE SERVICES.—The term
7 “health care services” means any services for which
8 payment may be made under a health plan, includ-
9 ing services related to the delivery or administration
10 of such services.

11 (5) HEALTH CARE PROFESSIONAL.—The term
12 “health care professional” means any individual or
13 entity that provides health care items or services,
14 treatment, assistance with activities of daily living,
15 or medications to patients and who, to the extent re-
16 quired by State or Federal law, possesses specialized
17 training that confers expertise in the provision of
18 such items or services, treatment, assistance, or
19 medications.

20 (6) HEALTH INSURANCE COVERAGE.—The term
21 “health insurance coverage” means benefits con-
22 sisting of medical care (provided directly, through
23 insurance or reimbursement, or otherwise and in-
24 cluding items and services paid for as medical care)
25 under any hospital or medical service policy or cer-

1 tificate, hospital or medical service plan contract, or
2 health maintenance organization contract offered by
3 a health insurance issuer.

4 (7) HEALTH INSURANCE ISSUER.—The term
5 “health insurance issuer” means an insurance com-
6 pany, insurance service, or insurance organization
7 (including a health maintenance organization) that
8 is licensed to engage in the business of insurance in
9 a State and that is subject to State law regulating
10 insurance. Such term does not include a group
11 health plan.

12 (8) HEALTH MAINTENANCE ORGANIZATION.—
13 The term “health maintenance organization”
14 means—

15 (A) a federally qualified health mainte-
16 nance organization (as defined in section
17 1301(a) of the Public Health Service Act (42
18 U.S.C. 300e(a)));

19 (B) an organization recognized under State
20 law as a health maintenance organization; or

21 (C) a similar organization regulated under
22 State law for solvency in the same manner and
23 to the same extent as such a health mainte-
24 nance organization.

1 (9) HEALTH PLAN.—The term “health plan”
2 means a group health plan or a health insurance
3 issuer that is offering health insurance coverage.

4 (10) MEDICAL CARE.—The term “medical
5 care” means amounts paid for—

6 (A) the diagnosis, cure, mitigation, treat-
7 ment, or prevention of disease, or amounts paid
8 for the purpose of affecting any structure or
9 function of the body; and

10 (B) transportation primarily for and essen-
11 tial to receiving items and services referred to
12 in subparagraph (A).

13 (11) PERSON.—The term “person” includes a
14 State or unit of local government.

15 (12) STATE.—The term “State” includes the
16 several States, the District of Columbia, Puerto
17 Rico, the Virgin Islands of the United States, Guam,
18 American Samoa, and the Commonwealth of the
19 Northern Mariana Islands.

20 (c) EFFECTIVE DATE.—This section shall take effect
21 on the date of the enactment of this Act and shall not
22 apply with respect to conduct occurring before such date.

1 **SEC. 602. CERTAIN MEDICAL STOP-LOSS INSURANCE OB-**
2 **TAINED BY CERTAIN PLAN SPONSORS OF**
3 **GROUP HEALTH PLANS NOT INCLUDED**
4 **UNDER THE DEFINITION OF HEALTH INSUR-**
5 **ANCE COVERAGE.**

6 (a) PHSA.—Section 2791(b)(1) of the Public Health
7 Service Act (42 U.S.C. 300gg–91(b)(1)) is amended by
8 adding at the end the following new sentence: “Such term
9 shall not include a stop loss policy obtained by a self-in-
10 sured health plan or a plan sponsor of a group health plan
11 that self-insures the health risks of its plan participants
12 to reimburse the plan or sponsor for losses that the plan
13 or sponsor incurs in providing health or medical benefits
14 to such plan participants in excess of a predetermined level
15 set forth in the stop loss policy obtained by such plan or
16 sponsor.”.

17 (b) ERISA.—Section 733(b)(1) of the Employee Re-
18 tirement Income Security Act of 1974 (29 U.S.C.
19 1191b(b)(1)) is amended by adding at the end the fol-
20 lowing new sentence: “Such term shall not include a stop
21 loss policy obtained by a self-insured health plan or a plan
22 sponsor of a group health plan that self-insures the health
23 risks of its plan participants to reimburse the plan or
24 sponsor for losses that the plan or sponsor incurs in pro-
25 viding health or medical benefits to such plan participants

1 in excess of a predetermined level set forth in the stop
2 loss policy obtained by such plan or sponsor.”.

3 (c) IRC.—Section 9832(b)(1)(A) of the Internal Rev-
4 enue Code of 1986 is amended by adding at the end the
5 following new sentence: “Such term shall not include a
6 stop loss policy obtained by a self-insured health plan or
7 a plan sponsor of a group health plan that self-insures
8 the health risks of its plan participants to reimburse the
9 plan or sponsor for losses that the plan or sponsor incurs
10 in providing health or medical benefits to such plan par-
11 ticipants in excess of a predetermined level set forth in
12 the stop loss policy obtained by such plan or sponsor.”.

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