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 bankruptey 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.

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-
- ing to ensuring that consumers get value for their
- 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

subsection (b), shall be redesignated as section 2706

- 1 and transferred so as to appear after section 2705 2 (as so redesignated).
 - (7) Section 2712, as restored or revived under subsection (b), shall be redesignated as section 2707 and transferred so as to appear after section 2706 (as so redesignated).
 - (8) Section 2714 (42 U.S.C. 300gg–14) shall be redesignated as section 2711 and transferred so as to appear as the first section under subpart II of part A.
 - (9) Section 2717 (42 U.S.C. 300gg–17) shall be redesignated as section 2712 and transferred so as to appear after section 2711 (as so redesignated).

(d) Effective Dates.—

- (1) IN GENERAL.—Except as provided in paragraph (2), the repeals under subsection (a) shall take effect on the date of enactment of this Act and shall apply to plan years beginning after such date of enactment.
- (2) DELAYED EFFECTIVE DATES.—The repeals under paragraphs (2), (3), (4), and (5) of subsection (a), the provisions restored or revived under subsection (b), and the conforming amendment in section 104(a)(2) shall be effective for plan years beginning 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	lie 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"; and
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

- treated as a qualified medical expense under either section 220(d) or 223(e).
- 3 "(3) DEDUCTION FOR MEDICAL EXPENSES.—
 4 For purposes of determining the amount of the de5 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:

[&]quot;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 premiums.".
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 redes-
17	ignating 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-
14 15	(a) In General.—Section 223 of the Internal Revenue Code of 1986, as amended by section 211, is further
15 16	enue Code of 1986, as amended by section 211, is further
15 16 17	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redes-
15 16 17 18	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections
15 16 17	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections (c), (d), (e), and (f), respectively.
15 16 17 18	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections (c), (d), (e), and (f), respectively. (b) Conforming Amendments.—
15 16 17 18 19	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections (e), (d), (e), and (f), respectively. (b) Conforming Amendments.— (1) Subsection (a) of section 223 of the Inter-
15 16 17 18 19 20 21	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections (c), (d), (e), and (f), respectively. (b) Conforming Amendments.— (1) Subsection (a) of section 223 of the Internal Revenue Code of 1986 is amended to read as fol-
15 16 17 18 19 20 21	enue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections (e), (d), (e), and (f), respectively. (b) Conforming Amendments.— (1) Subsection (a) of section 223 of the Internal Revenue Code of 1986 is amended to read as follows:

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 (e)(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(e)".
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(c)) 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(e)".
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-

ployer for only a portion of the calendar year,
a contribution to the health savings account of
such employee shall be treated as comparable if
it is an amount which bears the same ratio to
the comparable amount (determined without regard to this subparagraph) as such portion
bears to the entire calendar year.

"(3) Comparable participating employees of paragraph (1), the term 'comparable participating employees' means all employees who are covered (if at all) under the same health plan of the employer and have the same category of coverage. For purposes of the preceding sentence, the categories of coverage are self-only and family coverage.

"(4) PART-TIME EMPLOYEES.—

- "(A) IN GENERAL.—Paragraph (3) shall be applied separately with respect to part-time employees and other employees.
- "(B) Part-time employee.—For purposes of subparagraph (A), the term 'part-time employee' means any employee who is customarily employed for fewer than 30 hours per 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)
- and (b) shall apply to amounts paid in taxable years
- beginning after the date of the enactment of this
- 13 Act.
- 14 (2) Reimbursements.—The amendment made
- by subsection (c) shall apply to expenses incurred in
- plan years beginning after the date of the enactment
- 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.
13 14	able years beginning after such date. SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES
14	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES
14 15	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF AC-
14 15 16 17	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.
14 15 16 17	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT. (a) IN GENERAL.—Paragraph (2) of section 223(c)
14 15 16 17 18	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT. (a) IN GENERAL.—Paragraph (2) of section 223(c) of the Internal Revenue Code of 1986, as amended and
14 15 16 17 18	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT. (a) IN GENERAL.—Paragraph (2) of section 223(c) of the Internal Revenue Code of 1986, as amended and redesignated by the preceding sections of this subtitle, is
14 15 16 17 18 19 20	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT. (a) IN GENERAL.—Paragraph (2) of section 223(c) of the Internal Revenue Code of 1986, as amended and redesignated by the preceding sections of this subtitle, is further amended by adding at the end the following new
14 15 16 17 18 19 20 21	SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT. (a) IN GENERAL.—Paragraph (2) of section 223(c) of the Internal Revenue Code of 1986, as amended and redesignated by the preceding sections of this subtitle, is further amended by adding at the end the following new subparagraph:

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

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2	OF ACCOUNT HOLDER.
3	(a) In General.—Paragraph (7)(A) of section
4	223(e) of the Internal Revenue Code of 1986, as redesig-
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-
- tion, the term 'qualified HSA contribution' means
- an amount paid in cash during the taxable year by
- or on behalf of an individual to a health savings ac-
- count (as defined in section 223(c)) of such indi-
- vidual.
- 21 "(2) Exception for amounts not used for
- 22 QUALIFIED MEDICAL EXPENSES.—The amount
- taken into account as qualified HSA contributions of
- 24 the individual under paragraph (1) for a taxable
- year shall be reduced by the amount of any distribu-
- 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
- amount taken into account under subsection (a) with
- respect to any individual shall be reduced (but not
- below zero) by the amount of any credit allowed
- 20 under section 25E for qualified HSA contributions
- with respect to the individual.
- 22 "(2) Denial of Deduction to Depend-
- 23 ENTS.—No deduction shall be allowed under this
- section to any individual with respect to whom a de-
- 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.

Subtitle C—Medical Expenses 1 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 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.— "(A) IN GENERAL.—The term 'medical 10 11 care' shall include amounts paid— "(i) for equipment for use in a pro-12 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.— "(i) In General.—Amounts treated 22 23 as medical care under subparagraph (A) 24 shall not exceed \$1,000 with respect to any

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(c)(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
- shall be treated as amounts paid for medical care.".
- (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
	ter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:
16	by adding at the end the following new section:
16 17	by adding at the end the following new section: "SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED
161718	by adding at the end the following new section: "SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED CARE.
16171819	by adding at the end the following new section: "SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED CARE. "(a) IN GENERAL.—In the case of a physician, there
16 17 18 19 20	by adding at the end the following new section: "SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED CARE. "(a) IN GENERAL.—In the case of a physician, there shall be allowed as a deduction for the taxable year an
161718192021	by adding at the end the following new section: "SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED CARE. "(a) IN GENERAL.—In the case of a physician, there shall be allowed as a deduction for the taxable year an amount equal to the sum of—

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.

In the case of physicians' services to which such economic index is not applicable, the Secretary, in consultation with the Secretary of Health and Human Services, shall use data on uncompensated care for purposes of the limitation under subparagraph (B), and may adjust such data so as to be an appropriate proxy, including (in the case of qualified charity care) a downward adjustment to eliminate bad debt data from uncompensated care data.

- "(2) Overall limitation.—The amount allowed as a deduction under subsection (a) for any taxable year shall not exceed an amount equal to 10 percent of the gross income of the taxpayer for the taxable year derived from the taxpayer's provision of physicians' services.
- "(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)).".

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- 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.—

"(A) DIFFERENT GROUPS.—The IHP, in 1 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 members of the IHP and the dependents of 6 such members (and, in the case of small em-7 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 an IHP. 13 14 "(B) Nondiscrimination in coverage

OFFERED.—

- "(i) In general.—Subject to clause (ii), the IHP may not offer health benefits coverage to a member of an IHP unless the same coverage is offered to all such members of the IHP.
- "(ii) CONSTRUCTION.—Nothing this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law, or

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preventing a health insurance issuer from underwriting or from excluding or limiting the coverage on any individual, subject to the requirement of section 2741 (relating to guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage).

- "(C) No assumption of insurance risk by ihp.—The IHP provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.
- "(3) Geographic areas.—Nothing in this title shall be construed as preventing the establishment and operation of more than one IHP in a geographic area or as limiting the number of IHPs that may operate in any area.
- "(4) Provision of administrative services
 TO Purchasers.—The IHP may provide administrative services for members. Such services may include accounting, billing, and enrollment information.
- 23 "(b) Health Benefits Coverage Require-24 ments.—

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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.—

"(A) IN GENERAL.—Under rules established to carry out this title, with respect to an individual or small employer who is a member of an IHP, the individual may enroll for health benefits coverage (including coverage for dependents of such individual) or the employer may enroll employees for health benefits coverage (including coverage for dependents of such employees) offered by a health insurance issuer through the IHP.

"(B) RULES FOR ENROLLMENT.—Nothing in this paragraph shall preclude an IHP from establishing rules of enrollment and reenrollment of members. Such rules shall be applied consistently to all members within the IHP and shall not be based in any manner on health status-related factors.

"(2) HEALTH INSURANCE ISSUERS.—The contract between an IHP and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the IHP, for the payment to the issuer of the premiums (if any) collected by the IHP for 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

- "(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:
- "(1) DEPENDENT.—The term 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meaning applied to

such term with respect to such coverage under the laws of the State relating to such coverage and such an issuer. Such term may include the spouse and

children of the individual involved.

- "(2) HEALTH BENEFITS COVERAGE.—The term health benefits coverage' has the meaning given the term 'health insurance coverage' in section 2791(b)(1), and does not include excepted benefits (as defined in section 2791(c)).
 - "(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2).
 - "(4) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).
 - "(5) MEMBER.—The term 'member' means, with respect to an IHP, an individual or small employer who is a member of the legal entity described in section 3401(a)(1) to which the IHP is offering coverage.
 - "(6) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term in section 712(c)(1)(B) of the Employee Retirement Income Security Act of 1974.".

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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-

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

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- "(3) HEALTH INSURANCE ISSUER.—The term

 health insurance issuer' has the meaning given such

 term in section 2791(b)(2), except that such an

 issuer must be licensed in the primary State and be

 qualified to sell individual health insurance coverage

 in that State.
 - "(4) Individual Health Insurance coverage' means health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).
 - "(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of 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

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	surance 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 "(2) the solicitation or sale of individual health 5 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.— "(1) In general.—Subject to the provisions of 16 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 "(1) 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 indi3 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	with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at

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;

- "(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and
- "(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.
- 23 Any sponsor consisting of an association of entities which
- 24 meet the requirements of paragraphs (1), (2), and (3)

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- 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-

nesses or industries and whose eligible participating

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

> "(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

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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.—

vided in clauses (ii) and (iii), the members
of the board of trustees are individuals selected from individuals who are the owners,
officers, directors, or employees of the participating employers or who are partners in
the participating employers and actively
participate in the business.

"(ii) Limitation.—

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

"(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they

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1 do not provide services to the plan 2 other than on behalf of the sponsor. "(III)" TREATMENT 3 OF PRO-VIDERS OF MEDICAL CARE.—In the 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 maintained by a franchiser for a franchise network consisting 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'.
13 14	and 'franchisee'. "SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-
14	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-
14 15	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS.
14 15 16 17	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
14 15 16 17	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) Covered Employers and Individuals.—The requirements of this subsection are met with respect to
14 15 16 17	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) Covered Employers and Individuals.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the
114 115 116 117 118	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) Covered Employers and Individuals.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—
14 15 16 17 18 19 20	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) Covered Employers and Individuals.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan— "(1) each participating employer must be—
14 15 16 17 18 19 20 21	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan— "(1) each participating employer must be— "(A) a member of the sponsor;
14 15 16 17 18 19 20 21	"SEC. 804. PARTICIPATION AND COVERAGE REQUIRE- MENTS. "(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan— "(1) each participating employer must be— "(A) a member of the sponsor; "(B) the sponsor; or

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
- "(2) during the 12-month period preceding the
 date of the offering of such coverage, the affiliated
 member has not maintained or contributed to a
 group health plan with respect to any of its employees who would otherwise be eligible to participate in
 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, no participating employer may provide health insurance 13 14 coverage in the individual market for any employee not 15 covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer 16 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.
13	, , ,
14	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN
14	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN
14 15	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND
14 15 16 17	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.
14 15 16 17	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS. "(a) IN GENERAL.—The requirements of this section
14 15 16 17	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the
14 15 16 17 18	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:
14 15 16 17 18 19 20	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met: "(1) CONTENTS OF GOVERNING INSTRU-
14 15 16 17 18 19 20 21	"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met: "(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan in-

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-

ployers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

- "(B) STATE-LICENSED INSURANCE
 AGENTS.—For purposes of subparagraph (A),
 the term 'State-licensed insurance agents'
 means one or more agents who are licensed in
 a State and are subject to the laws of such
 State relating to licensure, qualification, testing, examination, and continuing education of
 persons authorized to offer, sell, or solicit
 health insurance coverage in such State.
- "(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.
- "(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
 nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude
 an association health plan, or a health insurance issuer
 offering health insurance coverage in connection with an
 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
1 4	FOR SOLVENOT FOR TEAMS TROVIDING
13	HEALTH BENEFITS IN ADDITION TO HEALTH
13	HEALTH BENEFITS IN ADDITION TO HEALTH
13 14	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.
13 14 15	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) IN GENERAL.—The requirements of this section
13 14 15 16	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—
13 14 15 16	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if— "(1) the benefits under the plan consist solely
113 114 115 116 117	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if— "(1) the benefits under the plan consist solely of health insurance coverage; or
13 14 15 16 17 18	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if— "(1) the benefits under the plan consist solely of health insurance coverage; or "(2) if the plan provides any additional benefits
13 14 15 16 17 18 19 20	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if— "(1) the benefits under the plan consist solely of health insurance coverage; or "(2) if the plan provides any additional benefit options which do not consist of health insurance coverage.
13 14 15 16 17 18 19 20 21	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) In General.—The requirements of this section are met with respect to an association health plan if— "(1) the benefits under the plan consist solely of health insurance coverage; or "(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—
13 14 15 16 17 18 19 20 21	HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE. "(a) In General.—The requirements of this section are met with respect to an association health plan if— "(1) the benefits under the plan consist solely of health insurance coverage; or "(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan— "(A) establishes and maintains reserves

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

in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified health actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in clause (i), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable author-

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- 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
- \$2,000,000) as may be set forth in regulations pre-
- scribed by the applicable authority, considering the
- level of aggregate and specific excess/stop loss insur-
- ance provided with respect to such plan and other
- factors related to solvency risk, such as the plan's
- projected levels of participation or claims, the nature
- of the plan's liabilities, and the types of assets avail-
- 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

- applicable terms of the plan in the form of assessments
- 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.—

CIATION HEALTH PLAN FUND.—

"(1) Payments by certain plans to asso-6 7

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.
 - "(C) CONTINUED DUTY OF THE SEC-RETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.
 - "(2) Payments by secretary to continue excess/stop loss insurance coverage and indemnification insurance coverage for certain plans.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the

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

"(3) Association health plan fund.—

"(A) IN GENERAL.—There is established in the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

"(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as 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

- plan and contract administrators and other service
 providers.
 - "(6) Funding report.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:
 - "(A) Reserves.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified health actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.
 - "(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified health actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the

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

"(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified health actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

- "(D) Costs of Coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.
- "(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to 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—
- "(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—
- "(1) the applicable authority has been notified
- under subsection (a) (or by an issuer of excess/stop
- loss insurance or indemnity insurance pursuant to
- section 806(a)) of a failure of an association health
- plan which is or has been certified under this part
- and is described in section 806(a)(2) to meet the re-
- quirements of section 806 and has not been notified
- by the board of trustees of the plan that corrective
- action has restored compliance with such require-
- 21 ments; and
- "(2) the applicable authority determines that
- 23 there is a reasonable expectation that the plan will
- 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
13 14	VIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.
14	
	HEALTH INSURANCE COVERAGE.
14 15 16	HEALTH INSURANCE COVERAGE. "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
14 15 16 17	HEALTH INSURANCE COVERAGE. "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines
14 15 16 17 18	HEALTH INSURANCE COVERAGE. "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been cer-
14 15 16 17 18	HEALTH INSURANCE COVERAGE. "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section
14 15 16 17 18	HEALTH INSURANCE COVERAGE. "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section $806(a)(2)$ will be unable to provide benefits when due or
14 15 16 17 18 19 20	HEALTH INSURANCE COVERAGE. "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section $806(a)(2)$ will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall
14 15 16 17 18 19 20 21	"(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section $806(a)(2)$ will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary
14 15 16 17 18 19 20 21 22 23	"(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section $806(a)(2)$ will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate

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—
- "(1) to do any act authorized by the plan, this
- title, or other applicable provisions of law to be done
- by the plan administrator or any trustee of the plan;
- 17 "(2) to require the transfer of all (or any part)
- 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,
- and applicable provisions of law;
- 24 "(4) to require the sponsor, the plan adminis-
- 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

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
- 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.

"(f) Jurisdiction of Court.—

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"(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the 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-

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

- "(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;
- "(3) such tax is otherwise nondiscriminatory; and

"(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations 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 $733(d)(2)$.

"(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) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.
 - "(10) QUALIFIED HEALTH ACTUARY.—The term 'qualified health actuary' means an individual who is a member of the American Academy of Actuaries with expertise in health care.
 - "(11) Affiliated member.—The term 'affiliated 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,

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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

association health plan, and for purposes of applying

this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

"(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

"(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

"(2) Plans, funds, and programs treated as employee welfare benefit plans.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program 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

I	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

such other employers are participating employers insuch plan.

"(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as defined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

- "(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, 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
- "(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

- 130 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) Section 514(e) of such Act (as redesignated 4 5 by paragraph (2)(C)) is amended— (A) by striking "Nothing" and inserting 6 "(1) Except as provided in paragraph (2), noth-7 ing"; and 8 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

[&]quot;801. Association health plans.

[&]quot;802. Certification of association health plans.

[&]quot;803. Requirements relating to sponsors and boards of trustees.

[&]quot;804. Participation and coverage requirements.

[&]quot;805. Other requirements relating to plan documents, contribution rates, and benefit options.

[&]quot;806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

[&]quot;807. Requirements for application and related requirements.

[&]quot;808. Notice requirements for voluntary termination.

[&]quot;809. Corrective actions and mandatory termination.

"810.	Trusteesh	ip by	the Se	ecretary	of i	nsolvent	associatio	n health	plans	pro-
		viding	; healtl	n benefi	ts in	addition	to health	insuranc	e covei	rage.
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"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
- 812(a)(2), two or more trades or businesses, wheth-
- 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
- businesses are within the same control group during
- such year or at any time during the preceding 1-year
- 16 period,";
- 17 (2) in clause (iii), by striking "(iii) the deter-
- mination" and inserting the following:
- "(iii)(I) in any case in which the benefit re-
- ferred to in subparagraph (A) consists of medical
- 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

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

- "(II) in any other case, the determination";
- (3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and
- (4) by inserting after clause (iii) the following new clause:

"(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is 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.".
14	The desired of the profit.
	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE
13	•
13 14	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE
13 14 15	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.
13 14 15 16	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES. Section 506 of the Employee Retirement Income Se-
13 14 15 16 17	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES. Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:
13 14 15 16 17	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES. Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:
13 14 15 16 17	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES. Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection: "(d) Consultation With States With Respect
13 14 15 16 17 18	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES. Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection: "(d) Consultation With States With Respect to Association Health Plans.—
13 14 15 16 17 18 19 20	SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES. Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection: "(d) Consultation With States With Respect to Association Health Plans.— "(1) AGREEMENTS WITH STATES.—The Sec-

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 s	EC.	405.	EFFECTIVE	DATE	AND	TRANSITIONAL	AND
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- 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
- the date of the enactment of this Act, an arrange-
- ment is maintained in a State for the purpose of
- providing benefits consisting of medical care for the
- employees and beneficiaries of its participating em-
- ployers, at least 200 participating employers make
- 17 contributions to such arrangement, such arrange-
- ment has been in existence for at least 10 years, and
- such arrangement is licensed under the laws of one
- or more States to provide such benefits to its par-
- 21 ticipating employers, upon the filing with the appli-
- 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	rangement 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

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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.

- (3) Group Health Plan, Health Insurance Issuer.—The terms "group health plan" and "health insurance issuer" include a third-party administrator or other person acting for or on behalf of such plan or issuer.
 - (4) Health care services.—The term "health care services" means any services for which payment may be made under a health plan, including services related to the delivery or administration of such services.
 - (5) Health care professional.—The term "health care professional" means any individual or entity that provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.
 - (6) Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) 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.

- (7) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a State and that is subject to State law regulating insurance. Such term does not include a group health plan.
- (8) HEALTH MAINTENANCE ORGANIZATION.—
 The term "health maintenance organization"
 means—
 - (A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a)));
 - (B) an organization recognized under State law as a health maintenance organization; or
 - (C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance 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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