113TH CONGRESS
1ST SESSION

H. R. 3622

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

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 22, 2013

Mr. DUFFY introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, the Judiciary, Natural Resources, House Administration, Rules, and Appropriations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**
4 (a) SHORT TITLE.—This Act may be cited as the
5 "Patient Centered Healthcare Savings Act of 2013".
6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—REPEALING OF PPACA

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

TITLE II—MEDICAL LIABILITY REFORM

Sec. 201. Findings and purpose.
Sec. 202. Encouraging speedy resolution of claims.
Sec. 203. Compensating patient injury.
Sec. 204. Maximizing patient recovery.
Sec. 205. Punitive damages.
Sec. 206. Authorization of payment of future damages to claimants in HEALTH care lawsuits.
Sec. 207. Definitions.
Sec. 208. Effect on other laws.
Sec. 209. State flexibility and protection of States' rights.
Sec. 210. Applicability; effective date.

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

Sec. 301. Specification of constitutional authority for enactment of law.
Sec. 302. Findings.
Sec. 303. Cooperative governing of individual health insurance coverage.
Sec. 304. Severability.

TITLE IV—INCREASING TRANSPARENCY AND COMPETITION IN HEALTHCARE

Sec. 401. Expanding availability of Medicare data.

TITLE V—EXPANDING THE EFFECTIVENESS OF HEALTH SAVINGS ACCOUNTS

Sec. 501. Amendment of 1986 Code.

Subtitle A—Provisions Relating to Tax-Preferred Health Accounts

Sec. 511. Allow both spouses to make catch-up contributions to the same HSA account.
Sec. 512. Provisions relating to Medicare.
Sec. 513. Individuals eligible for veterans benefits for a service-connected disability.
Sec. 514. Individuals eligible for Indian Health Service assistance.
Sec. 515. Individuals eligible for TRICARE coverage.
Sec. 516. Health FSA carryforwards.
Sec. 517. FSA and HRA interaction with HSAs.
Sec. 518. Allowance of distributions for prescription and over-the-counter medicines and drugs.
Sec. 519. Purchase of health insurance from HSA account.
Sec. 520. Special rule for certain medical expenses incurred before establishment of account.
Sec. 521. Preventive care prescription drug clarification.
Sec. 522. Equivalent bankruptcy protections for health savings accounts as retirement funds.
Sec. 523. Administrative error correction before due date of return.

Sec. 524. Reauthorization of medicaid health opportunity accounts.

Subtitle B—Other Provisions

Sec. 531. Certain exercise equipment and physical fitness programs treated as medical care.
Sec. 532. Certain nutritional and dietary supplements to be treated as medical care.
Sec. 533. Certain provider fees to be treated as medical care.

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

Subtitle A—Making Health Care Coverage Affordable for Every American

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

Sec. 601. Establish universal access programs to improve high risk pools and reinsurance markets.
Sec. 602. Elimination of certain requirements for guaranteed availability in individual market.
Sec. 603. No annual or lifetime spending caps.
Sec. 604. Preventing unjust cancellation of insurance coverage.

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

Sec. 611. State innovation programs.
Sec. 612. Health plan finders.
Sec. 613. Administrative simplification.

Subtitle B—Improving Access to Health Care

CHAPTER 1—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Sec. 620. Short title.
Sec. 621. Rules governing association health plans.
Sec. 622. Clarification of treatment of single employer arrangements.
Sec. 623. Enforcement provisions relating to association health plans.
Sec. 624. Cooperation between Federal and State authorities.
Sec. 625. Effective date and transitional and other rules.

CHAPTER 2—TARGETED EFFORTS TO EXPAND ACCESS

Sec. 631. Extending coverage of dependents.
Sec. 632. Allowing auto-enrollment for employer sponsored coverage.

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

Sec. 701. Increased civil money penalties and criminal fines for Medicare fraud and abuse.
Sec. 702. Increased sentences for felonies involving Medicare fraud and abuse.
Sec. 703. Other DME supplier anti-fraud and abuse provisions.
Sec. 704. Retention of certain fraud and abuse provisions.

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

TITLE I—REPEALING OF PPACA

SEC. 101. REPEAL OF THE HEALTH CARE REFORM PACKAGE.

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

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

TITLE II—MEDICAL LIABILITY REFORM

SEC. 201. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

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

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

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

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

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

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

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

1 (2) reduce the incidence of "defensive medi-
2 cine" and lower the cost of health care liability in-
3 surance, all of which contribute to the escalation of
4 health care costs;
5 (3) ensure that persons with meritorious health
6 care injury claims receive fair and adequate com-
7 pensation, including reasonable noneconomic dam-
8 ages;
9 (4) improve the fairness and cost-effectiveness
10 of our current health care liability system to resolve
11 disputes over, and provide compensation for, health
12 care liability by reducing uncertainty in the amount
13 of compensation provided to injured individuals; and
14 (5) provide an increased sharing of information
15 in the health care system which will reduce unin-
16 tended injury and improve patient care.
17 **SEC. 202. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**
18 The time for the commencement of a health care law-
19 suit shall be 3 years after the date of manifestation of
20 injury or 1 year after the claimant discovers, or through
21 the use of reasonable diligence should have discovered, the
22 injury, whichever occurs first. In no event shall the time
23 for commencement of a health care lawsuit exceed 3 years
24 after the date of manifestation of injury unless tolled for
25 any of the following—

1 (1) upon proof of fraud;
2 (2) intentional concealment; or
3 (3) the presence of a foreign body, which has no
4 therapeutic or diagnostic purpose or effect, in the
5 person of the injured person.
6 Actions by a minor shall be commenced within 3 years
7 from the date of the alleged manifestation of injury except
8 that actions by a minor under the full age of 6 years shall
9 be commenced within 3 years of manifestation of injury
10 or prior to the minor's 8th birthday, whichever provides
11 a longer period. Such time limitation shall be tolled for
12 minors for any period during which a parent or guardian
13 and a health care provider or health care organization
14 have committed fraud or collusion in the failure to bring
15 an action on behalf of the injured minor.
16 **SEC. 203. COMPENSATING PATIENT INJURY.**
17 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL
18 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any
19 health care lawsuit, nothing in this title shall limit a claim-
20 ant's recovery of the full amount of the available economic
21 damages, notwithstanding the limitation in subsection (b).
22 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any
23 health care lawsuit, the amount of noneconomic damages,
24 if available, may be as much as $250,000, regardless of
25 the number of parties against whom the action is brought

1 or the number of separate claims or actions brought with
2 respect to the same injury.
3 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC
4 DAMAGES.—For purposes of applying the limitation in
5 subsection (b), future noneconomic damages shall not be
6 discounted to present value. The jury shall not be in-
7 formed about the maximum award for noneconomic dam-
8 ages. An award for noneconomic damages in excess of
9 $250,000 shall be reduced either before the entry of judg-
10 ment, or by amendment of the judgment after entry of
11 judgment, and such reduction shall be made before ac-
12 counting for any other reduction in damages required by
13 law. If separate awards are rendered for past and future
14 noneconomic damages and the combined awards exceed
15 $250,000, the future noneconomic damages shall be re-
16 duced first.
17 (d) FAIR SHARE RULE.—In any health care lawsuit,
18 each party shall be liable for that party's several share
19 of any damages only and not for the share of any other
20 person. Each party shall be liable only for the amount of
21 damages allocated to such party in direct proportion to
22 such party's percentage of responsibility. Whenever a
23 judgment of liability is rendered as to any party, a sepa-
24 rate judgment shall be rendered against each such party
25 for the amount allocated to such party. For purposes of

1 this section, the trier of fact shall determine the propor-
2 tion of responsibility of each party for the claimant's
3 harm.

4 **SEC. 204. MAXIMIZING PATIENT RECOVERY.**

5 (a) COURT SUPERVISION OF SHARE OF DAMAGES
6 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
7 suit, the court shall supervise the arrangements for pay-
8 ment of damages to protect against conflicts of interest
9 that may have the effect of reducing the amount of dam-
10 ages awarded that are actually paid to claimants. In par-
11 ticular, in any health care lawsuit in which the attorney
12 for a party claims a financial stake in the outcome by vir-
13 tue of a contingent fee, the court shall have the power
14 to restrict the payment of a claimant's damage recovery
15 to such attorney, and to redirect such damages to the
16 claimant based upon the interests of justice and principles
17 of equity. In no event shall the total of all contingent fees
18 for representing all claimants in a health care lawsuit ex-
19 ceed the following limits:

20 (1) Forty percent of the first $50,000 recovered
21 by the claimant(s).

22 (2) Thirty-three and one-third percent of the
23 next $50,000 recovered by the claimant(s).

24 (3) Twenty-five percent of the next $500,000
25 recovered by the claimant(s).

1 (4) Fifteen percent of any amount by which the
2 recovery by the claimant(s) is in excess of $600,000.
3 (b) APPLICABILITY.—The limitations in this section
4 shall apply whether the recovery is by judgment, settle-
5 ment, mediation, arbitration, or any other form of alter-
6 native dispute resolution. In a health care lawsuit involv-
7 ing a minor or incompetent person, a court retains the
8 authority to authorize or approve a fee that is less than
9 the maximum permitted under this section. The require-
10 ment for court supervision in the first two sentences of
11 subsection (a) applies only in civil actions.

12 **SEC. 205. PUNITIVE DAMAGES.**

13 (a) IN GENERAL.—Punitive damages may, if other-
14 wise permitted by applicable State or Federal law, be
15 awarded against any person in a health care lawsuit only
16 if it is proven by clear and convincing evidence that such
17 person acted with malicious intent to injure the claimant,
18 or that such person deliberately failed to avoid unneces-
19 sary injury that such person knew the claimant was sub-
20 stantially certain to suffer. In any health care lawsuit
21 where no judgment for compensatory damages is rendered
22 against such person, no punitive damages may be awarded
23 with respect to the claim in such lawsuit. No demand for
24 punitive damages shall be included in a health care lawsuit
25 as initially filed. A court may allow a claimant to file an

1 amended pleading for punitive damages only upon a mo-
2 tion by the claimant and after a finding by the court, upon
3 review of supporting and opposing affidavits or after a
4 hearing, after weighing the evidence, that the claimant has
5 established by a substantial probability that the claimant
6 will prevail on the claim for punitive damages. At the re-
7 quest of any party in a health care lawsuit, the trier of
8 fact shall consider in a separate proceeding—
9 (1) whether punitive damages are to be award-
10 ed and the amount of such award; and
11 (2) the amount of punitive damages following a
12 determination of punitive liability.
13 If a separate proceeding is requested, evidence relevant
14 only to the claim for punitive damages, as determined by
15 applicable State law, shall be inadmissible in any pro-
16 ceeding to determine whether compensatory damages are
17 to be awarded.
18 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
19 AGES.—
20 (1) FACTORS CONSIDERED.—In determining
21 the amount of punitive damages, if awarded, in a
22 health care lawsuit, the trier of fact shall consider
23 only the following—
24 (A) the severity of the harm caused by the
25 conduct of such party;

1 (B) the duration of the conduct or any
2 concealment of it by such party;
3 (C) the profitability of the conduct to such
4 party;
5 (D) the number of products sold or med-
6 ical procedures rendered for compensation, as
7 the case may be, by such party, of the kind
8 causing the harm complained of by the claim-
9 ant;
10 (E) any criminal penalties imposed on such
11 party, as a result of the conduct complained of
12 by the claimant; and
13 (F) the amount of any civil fines assessed
14 against such party as a result of the conduct
15 complained of by the claimant.
16 (2) MAXIMUM AWARD.—The amount of punitive
17 damages, if awarded, in a health care lawsuit may
18 be as much as $250,000 or as much as two times
19 the amount of economic damages awarded, which-
20 ever is greater. The jury shall not be informed of
21 this limitation.
22 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT
23 COMPLY WITH FDA STANDARDS.—
24 (1) IN GENERAL.—

1 (A) No punitive damages may be awarded
2 against the manufacturer or distributor of a
3 medical product, or a supplier of any compo-
4 nent or raw material of such medical product,
5 based on a claim that such product caused the
6 claimant's harm where—
7 (i)(I) such medical product was sub-
8 ject to premarket approval, clearance, or li-
9 censure by the Food and Drug Administra-
10 tion with respect to the safety of the for-
11 mulation or performance of the aspect of
12 such medical product which caused the
13 claimant's harm or the adequacy of the
14 packaging or labeling of such medical
15 product; and
16 (II) such medical product was so ap-
17 proved, cleared, or licensed; or
18 (ii) such medical product is generally
19 recognized among qualified experts as safe
20 and effective pursuant to conditions estab-
21 lished by the Food and Drug Administra-
22 tion and applicable Food and Drug Admin-
23 istration regulations, including without
24 limitation those related to packaging and
25 labeling, unless the Food and Drug Admin-

istration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

1 (3) PACKAGING.—In a health care lawsuit for
2 harm which is alleged to relate to the adequacy of
3 the packaging or labeling of a drug which is required
4 to have tamper-resistant packaging under regula-
5 tions of the Secretary of Health and Human Serv-
6 ices (including labeling regulations related to such
7 packaging), the manufacturer or product seller of
8 the drug shall not be held liable for punitive dam-
9 ages unless such packaging or labeling is found by
10 the trier of fact by clear and convincing evidence to
11 be substantially out of compliance with such regula-
12 tions.
13 (4) EXCEPTION.—Paragraph (1) shall not
14 apply in any health care lawsuit in which—
15 (A) a person, before or after premarket ap-
16 proval, clearance, or licensure of such medical
17 product, knowingly misrepresented to or with-
18 held from the Food and Drug Administration
19 information that is required to be submitted
20 under the Federal Food, Drug, and Cosmetic
21 Act (21 U.S.C. 301 et seq.) or section 351 of
22 the Public Health Service Act (42 U.S.C. 262)
23 that is material and is causally related to the
24 harm which the claimant allegedly suffered; or

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.

SEC. 206. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments, in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this Act.

SEC. 207. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ‘‘alternative dispute resolution

1 system'' or ''ADR'' means a system that provides
2 for the resolution of health care lawsuits in a man-
3 ner other than through a civil action brought in a
4 State or Federal court.

5 (2) CLAIMANT.—The term ''claimant'' means
6 any person who brings a health care lawsuit, includ-
7 ing a person who asserts or claims a right to legal
8 or equitable contribution, indemnity, or subrogation,
9 arising out of a health care liability claim or action,
10 and any person on whose behalf such a claim is as-
11 serted or such an action is brought, whether de-
12 ceased, incompetent, or a minor.

13 (3) COMPENSATORY DAMAGES.—The term
14 ''compensatory damages'' means objectively
15 verifiable monetary losses incurred as a result of the
16 provision of, use of, or payment for (or failure to
17 provide, use, or pay for) health care services or med-
18 ical products, such as past and future medical ex-
19 penses, loss of past and future earnings, cost of ob-
20 taining domestic services, loss of employment, and
21 loss of business or employment opportunities, dam-
22 ages for physical and emotional pain, suffering, in-
23 convenience, physical impairment, mental anguish,
24 disfigurement, loss of enjoyment of life, loss of soci-
25 ety and companionship, loss of consortium (other

1 than loss of domestic service), hedonic damages, in-
2 jury to reputation, and all other nonpecuniary losses
3 of any kind or nature. The term ''compensatory
4 damages'' includes economic damages and non-
5 economic damages, as such terms are defined in this
6 section.

7 (4) CONTINGENT FEE.—The term ''contingent
8 fee'' includes all compensation to any person or per-
9 sons which is payable only if a recovery is effected
10 on behalf of one or more claimants.

11 (5) ECONOMIC DAMAGES.—The term ''economic
12 damages'' means objectively verifiable monetary
13 losses incurred as a result of the provision of, use
14 of, or payment for (or failure to provide, use, or pay
15 for) health care services or medical products, such as
16 past and future medical expenses, loss of past and
17 future earnings, cost of obtaining domestic services,
18 loss of employment, and loss of business or employ-
19 ment opportunities.

20 (6) HEALTH CARE LAWSUIT.—The term
21 ''health care lawsuit'' means any health care liability
22 claim concerning the provision of health care goods
23 or services or any medical product affecting inter-
24 state commerce, or any health care liability action
25 concerning the provision of health care goods or

1 services or any medical product affecting interstate
2 commerce, brought in a State or Federal court or
3 pursuant to an alternative dispute resolution system,
4 against a health care provider, a health care organi-
5 zation, or the manufacturer, distributor, supplier,
6 marketer, promoter, or seller of a medical product,
7 regardless of the theory of liability on which the
8 claim is based, or the number of claimants, plain-
9 tiffs, defendants, or other parties, or the number of
10 claims or causes of action, in which the claimant al-
11 leges a health care liability claim. Such term does
12 not include a claim or action which is based on
13 criminal liability; which seeks civil fines or penalties
14 paid to Federal, State, or local government; or which
15 is grounded in antitrust.

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

1 ties, or the number of causes of action, in which the
2 claimant alleges a health care liability claim.
3 (8) HEALTH CARE LIABILITY CLAIM.—The
4 term ‘‘health care liability claim’’ means a demand
5 by any person, whether or not pursuant to ADR,
6 against a health care provider, health care organiza-
7 tion, or the manufacturer, distributor, supplier, mar-
8 keter, promoter, or seller of a medical product, in-
9 cluding, but not limited to, third-party claims, cross-
10 claims, counter-claims, or contribution claims, which
11 are based upon the provision of, use of, or payment
12 for (or the failure to provide, use, or pay for) health
13 care services or medical products, regardless of the
14 theory of liability on which the claim is based, or the
15 number of plaintiffs, defendants, or other parties, or
16 the number of causes of action.
17 (9) HEALTH CARE ORGANIZATION.—The term
18 ‘‘health care organization’’ means any person or en-
19 tity which is obligated to provide or pay for health
20 benefits under any health plan, including any person
21 or entity acting under a contract or arrangement
22 with a health care organization to provide or admin-
23 ister any health benefit.
24 (10) HEALTH CARE PROVIDER.—The term
25 ‘‘health care provider’’ means any person or entity

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

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

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

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

1 Public Health Service Act (42 U.S.C. 262(a)), re-
2 spectively, including any component or raw material
3 used therein, but excluding health care services.
4 (14) NONECONOMIC DAMAGES.—The term
5 ''noneconomic damages'' means damages for phys-
6 ical and emotional pain, suffering, inconvenience,
7 physical impairment, mental anguish, disfigurement,
8 loss of enjoyment of life, loss of society and compan-
9 ionship, loss of consortium (other than loss of do-
10 mestic service), hedonic damages, injury to reputa-
11 tion, and all other nonpecuniary losses of any kind
12 or nature.
13 (15) PUNITIVE DAMAGES.—The term ''punitive
14 damages'' means damages awarded, for the purpose
15 of punishment or deterrence, and not solely for com-
16 pensatory purposes, against a health care provider,
17 health care organization, or a manufacturer, dis-
18 tributor, or supplier of a medical product. Punitive
19 damages are neither economic nor noneconomic
20 damages.
21 (16) RECOVERY.—The term ''recovery'' means
22 the net sum recovered after deducting any disburse-
23 ments or costs incurred in connection with prosecu-
24 tion or settlement of the claim, including all costs
25 paid or advanced by any person. Costs of health care

1 incurred by the plaintiff and the attorneys' office
2 overhead costs or charges for legal services are not
3 deductible disbursements or costs for such purpose.
4 (17) STATE.—The term ''State'' means each of
5 the several States, the District of Columbia, the
6 Commonwealth of Puerto Rico, the Virgin Islands,
7 Guam, American Samoa, the Northern Mariana Is-
8 lands, the Trust Territory of the Pacific Islands, and
9 any other territory or possession of the United
10 States, or any political subdivision thereof.

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

12 (a) VACCINE INJURY.—
13 (1) To the extent that title XXI of the Public
14 Health Service Act establishes a Federal rule of law
15 applicable to a civil action brought for a vaccine-re-
16 lated injury or death—
17 (A) this title does not affect the application
18 of the rule of law to such an action; and
19 (B) any rule of law prescribed by this title
20 in conflict with a rule of law of such title XXI
21 shall not apply to such action.
22 (2) If there is an aspect of a civil action
23 brought for a vaccine-related injury or death to
24 which a Federal rule of law under title XXI of the
25 Public Health Service Act does not apply, then this

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 **SEC. 302. FINDINGS.**

23 Congress finds the following:

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

1 the Patient Protection and Affordable Care Act im-
2 pacts the ability of insurers to offer, and individuals
3 to obtain, affordable individual health insurance cov-
4 erage, thereby impeding commerce in individual
5 health insurance coverage.
6 (2) Mandates for health care coverage estab-
7 lished by title I of the Patient Protection and Af-
8 fordable Care Act will significantly elevate health in-
9 surance costs beyond State and Federal ability to
10 pay.
11 (3) Individual health insurance coverage is in-
12 creasingly offered through the Internet, other elec-
13 tronic means, and by mail, all of which are inher-
14 ently part of interstate commerce.
15 (4) In response to these issues, it is appropriate
16 to encourage increased efficiency in the offering of
17 individual health insurance coverage through a col-
18 laborative approach by the States in regulating this
19 coverage.
20 (5) The establishment of risk-retention groups
21 has provided a successful model for the sale of insur-
22 ance across State lines, as the acts establishing
23 those groups allow insurance to be sold in multiple
24 States but regulated by a single State.

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

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

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

8 **"SEC. 2795. DEFINITIONS.**

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

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

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

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

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

24 "(6) HAZARDOUS FINANCIAL CONDITION.—The
25 term 'hazardous financial condition' means that,

1 based on its present or reasonably anticipated finan-
2 cial condition, a health insurance issuer is unlikely
3 to be able—
4 ''(A) to meet obligations to policyholders
5 with respect to known claims and reasonably
6 anticipated claims; or
7 ''(B) to pay other obligations in the normal
8 course of business.
9 ''(7) COVERED LAWS.—
10 ''(A) IN GENERAL.—The term 'covered
11 laws' means the laws, rules, regulations, agree-
12 ments, and orders governing the insurance busi-
13 ness pertaining to—
14 ''(i) individual health insurance cov-
15 erage issued by a health insurance issuer;
16 ''(ii) the offer, sale, rating (including
17 medical underwriting), renewal, and
18 issuance of individual health insurance cov-
19 erage to an individual;
20 ''(iii) the provision to an individual in
21 relation to individual health insurance cov-
22 erage of health care and insurance related
23 services;
24 ''(iv) the provision to an individual in
25 relation to individual health insurance cov-

1 erage of management, operations, and in-
2 vestment activities of a health insurance
3 issuer; and
4 "(v) the provision to an individual in
5 relation to individual health insurance cov-
6 erage of loss control and claims adminis-
7 tration for a health insurance issuer with
8 respect to liability for which the issuer pro-
9 vides insurance.
10 "(B) EXCEPTION.—Such term does not in-
11 clude any law, rule, regulation, agreement, or
12 order governing the use of care or cost manage-
13 ment techniques, including any requirement re-
14 lated to provider contracting, network access or
15 adequacy, health care data collection, or quality
16 assurance.
17 "(8) STATE.—The term 'State' means the 50
18 States and includes the District of Columbia, Puerto
19 Rico, the Virgin Islands, Guam, American Samoa,
20 and the Northern Mariana Islands.
21 "(9) UNFAIR CLAIMS SETTLEMENT PRAC-
22 TICES.—The term 'unfair claims settlement prac-
23 tices' means only the following practices:

1 "(A) Knowingly misrepresenting to claim-
2 ants and insured individuals relevant facts or
3 policy provisions relating to coverage at issue.
4 "(B) Failing to acknowledge with reason-
5 able promptness pertinent communications with
6 respect to claims arising under policies.
7 "(C) Failing to adopt and implement rea-
8 sonable standards for the prompt investigation
9 and settlement of claims arising under policies.
10 "(D) Failing to effectuate prompt, fair,
11 and equitable settlement of claims submitted in
12 which liability has become reasonably clear.
13 "(E) Refusing to pay claims without con-
14 ducting a reasonable investigation.
15 "(F) Failing to affirm or deny coverage of
16 claims within a reasonable period of time after
17 having completed an investigation related to
18 those claims.
19 "(G) A pattern or practice of compelling
20 insured individuals or their beneficiaries to in-
21 stitute suits to recover amounts due under its
22 policies by offering substantially less than the
23 amounts ultimately recovered in suits brought
24 by them.

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

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

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

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

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

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

1 will be presented to or by an insurer, a rein-
2 surer, broker or its agent, false information as
3 part of, in support of or concerning a fact ma-
4 terial to one or more of the following:
5 ''(i) An application for the issuance or
6 renewal of an insurance policy or reinsur-
7 ance contract.
8 ''(ii) The rating of an insurance policy
9 or reinsurance contract.
10 ''(iii) A claim for payment or benefit
11 pursuant to an insurance policy or reinsur-
12 ance contract.
13 ''(iv) Premiums paid on an insurance
14 policy or reinsurance contract.
15 ''(v) Payments made in accordance
16 with the terms of an insurance policy or
17 reinsurance contract.
18 ''(vi) A document filed with the com-
19 missioner or the chief insurance regulatory
20 official of another jurisdiction.
21 ''(vii) The financial condition of an in-
22 surer or reinsurer.
23 ''(viii) The formation, acquisition,
24 merger, reconsolidation, dissolution or
25 withdrawal from one or more lines of in-

surance or reinsurance in all or part of a State by an insurer or reinsurer.

"(ix) The issuance of written evidence of insurance.

"(x) The reinstatement of an insurance policy.

"(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

"(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

"(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

"SEC. 2796. APPLICATION OF LAW.

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

1 and in any secondary State, but only if the coverage and
2 issuer comply with the conditions of this section with re-
3 spect to the offering of coverage in any secondary State.
4 "(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
5 ONDARY STATE.—Except as provided in this section, a
6 health insurance issuer with respect to its offer, sale, rat-
7 ing (including medical underwriting), renewal, and
8 issuance of individual health insurance coverage in any
9 secondary State is exempt from any covered laws of the
10 secondary State (and any rules, regulations, agreements,
11 or orders sought or issued by such State under or related
12 to such covered laws) to the extent that such laws would—
13 "(1) make unlawful, or regulate, directly or in-
14 directly, the operation of the health insurance issuer
15 operating in the secondary State, except that any
16 secondary State may require such an issuer—
17 "(A) to pay, on a nondiscriminatory basis,
18 applicable premium and other taxes (including
19 high risk pool assessments) which are levied on
20 insurers and surplus lines insurers, brokers, or
21 policyholders under the laws of the State;
22 "(B) to register with and designate the
23 State insurance commissioner as its agent solely
24 for the purpose of receiving service of legal doc-
25 uments or process;

1 "(C) to submit to an examination of its fi-
2 nancial condition by the State insurance com-
3 missioner in any State in which the issuer is
4 doing business to determine the issuer's finan-
5 cial condition, if—
6 "(i) the State insurance commissioner
7 of the primary State has not done an ex-
8 amination within the period recommended
9 by the National Association of Insurance
10 Commissioners; and
11 "(ii) any such examination is con-
12 ducted in accordance with the examiners'
13 handbook of the National Association of
14 Insurance Commissioners and is coordi-
15 nated to avoid unjustified duplication and
16 unjustified repetition;
17 "(D) to comply with a lawful order
18 issued—
19 "(i) in a delinquency proceeding com-
20 menced by the State insurance commis-
21 sioner if there has been a finding of finan-
22 cial impairment under subparagraph (C);
23 or
24 "(ii) in a voluntary dissolution pro-
25 ceeding;

1 "(E) to comply with an injunction issued
2 by a court of competent jurisdiction, upon a pe-
3 tition by the State insurance commissioner al-
4 leging that the issuer is in hazardous financial
5 condition;
6 "(F) to participate, on a nondiscriminatory
7 basis, in any insurance insolvency guaranty as-
8 sociation or similar association to which a
9 health insurance issuer in the State is required
10 to belong;
11 "(G) to comply with any State law regard-
12 ing fraud and abuse (as defined in section
13 2795(10)), except that if the State seeks an in-
14 junction regarding the conduct described in this
15 subparagraph, such injunction must be obtained
16 from a court of competent jurisdiction;
17 "(H) to comply with any State law regard-
18 ing unfair claims settlement practices (as de-
19 fined in section 2795(9)); or
20 "(I) to comply with the applicable require-
21 ments for independent review under section
22 2798 with respect to coverage offered in the
23 State;
24 "(2) require any individual health insurance
25 coverage issued by the issuer to be countersigned by

1 an insurance agent or broker residing in that Sec-
2 ondary State; or
3 "(3) otherwise discriminate against the issuer
4 issuing insurance in both the primary State and in
5 any secondary State.
6 "(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
7 health insurance issuer shall provide the following notice,
8 in 12-point bold type, in any insurance coverage offered
9 in a secondary State under this part by such a health in-
10 surance issuer and at renewal of the policy, with the 5
11 blank spaces therein being appropriately filled with the
12 name of the health insurance issuer, the name of primary
13 State, the name of the secondary State, the name of the
14 secondary State, and the name of the secondary State, re-
15 spectively, for the coverage concerned:
16 " 'NOTICE
17 " 'This policy is issued by __________ and is gov-
18 erned by the laws and regulations of the State of
19 __________, and it has met all the laws of that State as
20 determined by that State's Department of Insurance. This
21 policy may be less expensive than others because it is not
22 subject to all of the insurance laws and regulations of the
23 State of __________, including coverage of some services
24 or benefits mandated by the law of the State of
25 __________. Additionally, this policy is not subject to all

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

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

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

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

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

1 "(2) CONSTRUCTION.—Nothing in paragraph
2 (1) shall be construed to prohibit a health insurance
3 issuer—
4 "(A) from terminating or discontinuing
5 coverage or a class of coverage in accordance
6 with subsections (b) and (c) of section 2742;
7 "(B) from raising premium rates for all
8 policy holders within a class based on claims ex-
9 perience;
10 "(C) from changing premiums or offering
11 discounted premiums to individuals who engage
12 in wellness activities at intervals prescribed by
13 the issuer, if such premium changes or incen-
14 tives—
15 "(i) are disclosed to the consumer in
16 the insurance contract;
17 "(ii) are based on specific wellness ac-
18 tivities that are not applicable to all indi-
19 viduals; and
20 "(iii) are not obtainable by all individ-
21 uals to whom coverage is offered;
22 "(D) from reinstating lapsed coverage; or
23 "(E) from retroactively adjusting the rates
24 charged an insured individual if the initial rates

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

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

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

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

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

1 ''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

''(A) a member of the American Academy of Actuaries; or

''(B) a qualified loss reserve specialist.

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

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

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

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

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

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

23 "(2) COURTS OF COMPETENT JURISDICTION.—
24 If a State seeks an injunction regarding the conduct
25 described in paragraphs (1) and (2) of subsection

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

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

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

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

"SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

"A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

"(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

"(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier Ex-

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

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

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

"(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

"(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

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

1 "(2) LICENSURE AND EXPERTISE.—Each inde-
2 pendent medical reviewer shall be a physician
3 (allopathic or osteopathic) or health care profes-
4 sional who—
5 "(A) is appropriately credentialed or li-
6 censed in 1 or more States to deliver health
7 care services; and
8 "(B) typically treats the condition, makes
9 the diagnosis, or provides the type of treatment
10 under review.
11 "(3) INDEPENDENCE.—
12 "(A) IN GENERAL.—Subject to subpara-
13 graph (B), each independent medical reviewer
14 in a case shall—
15 "(i) not be a related party (as defined
16 in paragraph (7));
17 "(ii) not have a material familial, fi-
18 nancial, or professional relationship with
19 such a party; and
20 "(iii) not otherwise have a conflict of
21 interest with such a party (as determined
22 under regulations).
23 "(B) EXCEPTION.—Nothing in subpara-
24 graph (A) shall be construed to—

1 "(i) prohibit an individual, solely on
2 the basis of affiliation with the issuer,
3 from serving as an independent medical re-
4 viewer if—
5 "(I) a non-affiliated individual is
6 not reasonably available;
7 "(II) the affiliated individual is
8 not involved in the provision of items
9 or services in the case under review;
10 "(III) the fact of such an affili-
11 ation is disclosed to the issuer and the
12 enrollee (or authorized representative)
13 and neither party objects; and
14 "(IV) the affiliated individual is
15 not an employee of the issuer and
16 does not provide services exclusively or
17 primarily to or on behalf of the issuer;
18 "(ii) prohibit an individual who has
19 staff privileges at the institution where the
20 treatment involved takes place from serv-
21 ing as an independent medical reviewer
22 merely on the basis of such affiliation if
23 the affiliation is disclosed to the issuer and
24 the enrollee (or authorized representative),
25 and neither party objects; or

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

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

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

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

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

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

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

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

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

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

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

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

1 respect to a denial of a claim under a coverage relat-
2 ing to an enrollee, any of the following:
3 ‘‘(A) The issuer involved, or any fiduciary,
4 officer, director, or employee of the issuer.
5 ‘‘(B) The enrollee (or authorized represent-
6 ative).
7 ‘‘(C) The health care professional that pro-
8 vides the items or services involved in the de-
9 nial.
10 ‘‘(D) The institution at which the items or
11 services (or treatment) involved in the denial
12 are provided.
13 ‘‘(E) The manufacturer of any drug or
14 other item that is included in the items or serv-
15 ices involved in the denial.
16 ‘‘(F) Any other party determined under
17 any regulations to have a substantial interest in
18 the denial involved.
19 ‘‘(8) DEFINITIONS.—For purposes of this sub-
20 section:
21 ‘‘(A) ENROLLEE.—The term ‘enrollee’
22 means, with respect to health insurance cov-
23 erage offered by a health insurance issuer, an
24 individual enrolled with the issuer to receive
25 such coverage.

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

7 **"SEC. 2799. ENFORCEMENT.**

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

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

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

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

1 secondary State may notify the applicable State authority
2 of the primary State.''.
3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to individual health insurance
5 coverage offered, issued, or sold after the date that is one
6 year after the date of the enactment of this Act.
7 (c) GAO ONGOING STUDY AND REPORTS.—
8 (1) STUDY.—The Comptroller General of the
9 United States shall conduct an ongoing study con-
10 cerning the effect of the amendment made by sub-
11 section (a) on—
12 (A) the number of uninsured and under-in-
13 sured;
14 (B) the availability and cost of health in-
15 surance policies for individuals with pre-existing
16 medical conditions;
17 (C) the availability and cost of health in-
18 surance policies generally;
19 (D) the elimination or reduction of dif-
20 ferent types of benefits under health insurance
21 policies offered in different States; and
22 (E) cases of fraud or abuse relating to
23 health insurance coverage offered under such
24 amendment and the resolution of such cases.

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

6 **SEC. 304. SEVERABILITY.**

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

12 TITLE IV—INCREASING TRANS- 13 PARENCY AND COMPETITION 14 IN HEALTHCARE

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

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

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

from the evaluation described in such paragraph (4)(D), for additional non-public analyses (as determined appropriate by the Secretary of Health and Human Services) or provide or sell such data to registered or authorized users and subscribers, including to providers of services and suppliers, for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(2) DEFINITIONS.—In this section:

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

(B) The terms ''supplier'' and ''provider of services'' have the meanings given such terms in subsections (d) and (u), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

(b) ACCESS TO MEDICARE DATA TO PROVIDERS OF SERVICES AND SUPPLIERS TO FACILITATE DEVELOPMENT OF ALTERNATIVE PAYMENT MODELS AND TO QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Consistent with applicable

1 laws and regulations with respect to privacy and other rel-
2 evant matters, the Secretary shall provide Medicare claims
3 data (in a form and manner determined to be appropriate)
4 to—
5 (1) qualified entities, that may share with pro-
6 viders of services and suppliers that are registered or
7 authorized users or subscribers, for non-public use
8 including to facilitate the development of new models
9 of care (including development of Alternate Payment
10 Models under section 1848A of the Social Security
11 Act, models for small group specialty practices, and
12 care coordination models); and
13 (2) qualified clinical data registries under sec-
14 tion 1848(m)(3)(E) of the Social Security Act (42
15 U.S.C. 1395w–4(m)(3)(E)) for purposes of linking
16 such data with clinical outcomes data and per-
17 forming and disseminating risk-adjusted, scientif-
18 ically valid analysis and research to support quality
19 improvement or patient safety, provided that any
20 public reporting of identifiable provider data shall
21 only be conducted with prior consent of such pro-
22 vider.

TITLE V—EXPANDING THE EFFECTIVENESS OF HEALTH SAVINGS ACCOUNTS

SEC. 501. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Provisions Relating to Tax-Preferred Health Accounts

SEC. 511. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HSA ACCOUNT.

(a) IN GENERAL.—Paragraph (3) of section 223(b) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE WHERE BOTH SPOUSES ARE ELIGIBLE INDIVIDUALS WITH 1 ACCOUNT.—If—

"(i) an individual and the individual's spouse have both attained age 55 before the close of the taxable year, and

1 "(ii) the spouse is not an account ben-
2 eficiary of a health savings account as of
3 the close of such year,
4 the additional contribution amount shall be 200
5 percent of the amount otherwise determined
6 under subparagraph (B).".
7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall apply to taxable years beginning after
9 the date of the enactment of this Act.

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

11 (a) INDIVIDUALS OVER AGE 65 ONLY ENROLLED IN
12 MEDICARE PART A.—Paragraph (7) of section 223(b) is
13 amended by adding at the end the following: "This para-
14 graph shall not apply to any individual during any period
15 for which the individual's only entitlement to such benefits
16 is an entitlement to hospital insurance benefits under part
17 A of title XVIII of such Act pursuant to an enrollment
18 for such hospital insurance benefits under section
19 226(a)(1) of such Act.".
20 (b) MEDICARE BENEFICIARIES PARTICIPATING IN
21 MEDICARE ADVANTAGE MSA MAY CONTRIBUTE THEIR
22 OWN MONEY TO THEIR MSA.—Subsection (b) of section
23 138 is amended by striking paragraph (2) and by redesig-
24 nating paragraphs (3) and (4) as paragraphs (2) and (3),
25 respectively.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 "(2) CARRYFORWARD OF UNUSED BENEFITS IN
2 HEALTH ARRANGEMENTS.—
3 "(A) IN GENERAL.—A plan or arrange-
4 ment may permit a participant in a health flexi-
5 ble spending arrangement to elect to carry for-
6 ward any aggregate unused balances in the par-
7 ticipant's accounts under such arrangement as
8 of the close of any year to the succeeding year.
9 Such carryforward shall be treated as having
10 occurred within 30 days of the close of the year.
11 "(B) DOLLAR LIMIT ON
12 CARRYFORWARDS.—
13 "(i) IN GENERAL.—The amount which
14 a participant may elect to carry forward
15 under subparagraph (A) from any year
16 shall not exceed $500. For purposes of this
17 paragraph, all plans and arrangements
18 maintained by an employer or any related
19 person shall be treated as 1 plan.
20 "(ii) COST-OF-LIVING ADJUSTMENT.—
21 In the case of any taxable year beginning
22 in a calendar year after 2013, the $500
23 amount under clause (i) shall be increased
24 by an amount equal to—
25 "(I) $500, multiplied by

1 "(II) the cost-of-living adjust-
2 ment determined under section 1(f)(3)
3 for such calendar year, determined by
4 substituting '2012' for '1992' in sub-
5 paragraph (B) thereof.
6 If any dollar amount as increased under
7 this clause is not a multiple of $100, such
8 amount shall be rounded to the next lowest
9 multiple of $100.
10 "(C) EXCLUSION FROM GROSS INCOME.—
11 No amount shall be required to be included in
12 gross income under this chapter by reason of
13 any carryforward under this paragraph.
14 "(D) COORDINATION WITH LIMITS.—The
15 maximum amount which may be contributed to
16 a health flexible spending arrangement for any
17 year to which an unused amount is carried
18 under this paragraph shall be reduced by such
19 amount.
20 "(3) TERMS RELATING TO FLEXIBLE SPENDING
21 ARRANGEMENTS.—
22 "(A) FLEXIBLE SPENDING ARRANGE-
23 MENTS.—For purposes of this subsection, a
24 flexible spending arrangement is a benefit pro-
25 gram which provides employees with coverage

1 under which specified incurred expenses may be
2 reimbursed (subject to reimbursement maxi-
3 mums and other reasonable conditions).
4 ''(B) HEALTH ARRANGEMENTS.—The term
5 'health flexible spending arrangement' means
6 any flexible spending arrangement (or portion
7 thereof) which provides payments for expenses
8 incurred for medical care (as defined in section
9 213(d)).''.
10 (b) CONFORMING AMENDMENTS.—
11 (1) The heading for section 125 of the Internal
12 Revenue Code of 1986 is amended by inserting
13 ''**AND HEALTH FLEXIBLE SPENDING ARRANGE-**
14 **MENTS**'' after ''**PLANS**''.
15 (2) The item relating to section 125 in the table
16 of sections for part III of subchapter B of chapter
17 1 of such Code is amended by inserting ''and health
18 flexible spending arrangements'' after ''plans''.
19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall take effect on the date of the enactment
21 of this Act.
22 **SEC. 517. FSA AND HRA INTERACTION WITH HSAS.**
23 (a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA
24 PARTICIPANTS.—Subparagraph (B) of section 223(c)(1)
25 is amended—

1 (1) by striking "and" at the end of clause (ii),
2 (2) by striking the period at the end of clause
3 (iii) and inserting ", and", and
4 (3) by inserting after clause (iii) the following
5 new clause:
6 "(iv) coverage under a health flexible
7 spending arrangement or a health reim-
8 bursement arrangement in the plan year a
9 qualified HSA distribution as described in
10 section 106(e) is made on behalf of the in-
11 dividual if after the qualified HSA dis-
12 tribution is made and for the remaining
13 duration of the plan year, the coverage
14 provided under the health flexible spending
15 arrangement or health reimbursement ar-
16 rangement is converted to—
17 "(I) coverage that does not pay
18 or reimburse any medical expense in-
19 curred before the minimum annual de-
20 ductible under paragraph (2)(A)(i)
21 (prorated for the period occurring
22 after the qualified HSA distribution is
23 made) is satisfied,
24 "(II) coverage that, after the
25 qualified HSA distribution is made,

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

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

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

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

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

1 suspended, pursuant to an election
2 made on or before the date the indi-
3 vidual elects a qualified HSA distribu-
4 tion or, if later, on the date of the in-
5 dividual enrolls in a high deductible
6 health plan, that does not pay or re-
7 imburse, at any time, any medical ex-
8 pense incurred during the suspension
9 period except as defined in the pre-
10 ceding subclauses of this clause.''.
11 (b) QUALIFIED HSA DISTRIBUTION SHALL NOT AF-
12 FECT FLEXIBLE SPENDING ARRANGEMENT.—Paragraph
13 (1) of section 106(e) is amended to read as follows:
14 ''(1) IN GENERAL.—A plan shall not fail to be
15 treated as a health flexible spending arrangement
16 under this section, section 105, or section 125, or as
17 a health reimbursement arrangement under this sec-
18 tion or section 105, merely because such plan pro-
19 vides for a qualified HSA distribution.''.
20 (c) FSA BALANCES AT YEAR END SHALL NOT FOR-
21 FEIT.—Paragraph (2) of section 125(d) is amended by
22 adding at the end the following new subparagraph:
23 ''(E) EXCEPTION FOR QUALIFIED HSA DIS-
24 TRIBUTIONS.—Subparagraph (A) shall not
25 apply to the extent that there is an amount re-

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

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

9 ''(2) QUALIFIED HSA DISTRIBUTION.—

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

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

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

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

22 ''(B) DOLLAR LIMITATIONS.—

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

1 flexible spending arrangement shall not ex-
2 ceed the applicable amount.
3 "(ii) DISTRIBUTIONS FROM A HEALTH
4 REIMBURSEMENT ARRANGEMENT.—A
5 qualified HSA distribution from a health
6 reimbursement arrangement shall not ex-
7 ceed—
8 "(I) the applicable amount di-
9 vided by 12, multiplied by
10 "(II) the number of months dur-
11 ing which the individual is a partici-
12 pant in the health reimbursement ar-
13 rangement.
14 "(iii) APPLICABLE AMOUNT.—For
15 purposes of this subparagraph, the applica-
16 ble amount is—
17 "(I) $2,250 in the case of an eli-
18 gible individual who has self-only cov-
19 erage under a high deductible health
20 plan at the time of such distribution,
21 and
22 "(II) $4,500 in the case of an eli-
23 gible individual who has family cov-
24 erage under a high deductible health

1 plan at the time of such distribu-
2 tion.''.
3 (e) ELIMINATION OF ADDITIONAL TAX FOR FAILURE
4 TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COV-
5 ERAGE.—Subsection (e) of section 106 is amended—
6 (1) by striking paragraph (3) and redesignating
7 paragraphs (4) and (5) as paragraphs (3) and (4),
8 respectively, and
9 (2) by striking subparagraph (A) of paragraph
10 (3), as so redesignated, and redesignating subpara-
11 graphs (B) and (C) of such paragraph as subpara-
12 graphs (A) and (B) thereof, respectively.
13 (f) LIMITED PURPOSE FSAS AND HRAS.—Sub-
14 section (e) of section 106, as amended by this section, is
15 amended by adding at the end the following new para-
16 graph:
17 ''(5) LIMITED PURPOSE FSAS AND HRAS.—A
18 plan shall not fail to be a health flexible spending
19 arrangement or health reimbursement arrangement
20 under this section or section 105 merely because the
21 plan converts coverage for individuals who enroll in
22 a high deductible health plan described in section
23 223(c)(2) to coverage described in section
24 223(c)(1)(B)(iv). Coverage for such individuals may
25 be converted as of the date of enrollment in the high

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

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

11 ''(6) COST-OF-LIVING ADJUSTMENT.—

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

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

1 (h) DISCLAIMER OF DISQUALIFYING COVERAGE.—
2 Subparagraph (B) of section 223(c)(1), as amended by
3 this section, is amended—
4 (1) by striking ''and'' at the end of clause (iii),
5 (2) by striking the period at the end of clause
6 (iv) and inserting '', and'', and
7 (3) by inserting after clause (iv) the following
8 new clause:
9 ''(v) any coverage (including prospec-
10 tive coverage) under a health plan that is
11 not a high deductible health plan which is
12 disclaimed in writing, at the time of the
13 creation or organization of the health sav-
14 ings account, including by execution of a
15 trust described in subsection (d)(1)
16 through a governing instrument that in-
17 cludes such a disclaimer, or by acceptance
18 of an amendment to such a trust that in-
19 cludes such a disclaimer.''.
20 (i) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 the date of the enactment of this Act.

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

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

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

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

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

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

1 MENTS.—Section 106 is amended by adding at the
2 end the following new subsection:
3 ''(f) REIMBURSEMENTS FOR ALL MEDICINES AND
4 DRUGS.—For purposes of this section and section 105,
5 reimbursement for expenses incurred for any prescription
6 or over-the-counter medicine or drug shall be treated as
7 a reimbursement for medical expenses.''.
8 (4) EFFECTIVE DATES.—
9 (A) DISTRIBUTIONS FROM SAVINGS AC-
10 COUNTS.—The amendments made by para-
11 graphs (1) and (2) shall apply to amounts paid
12 with respect to taxable years beginning after
13 December 31, 2013.
14 (B) REIMBURSEMENTS.—The amendment
15 made by paragraph (3) shall apply to expenses
16 incurred with respect to taxable years beginning
17 after December 31, 2013.
18 **SEC. 519. PURCHASE OF HEALTH INSURANCE FROM HSA**
19 **ACCOUNT.**
20 (a) IN GENERAL.—Paragraph (2) of section 223(d)
21 is amended to read as follows:
22 ''(2) QUALIFIED MEDICAL EXPENSES.—
23 ''(A) IN GENERAL.—The term 'qualified
24 medical expenses' means, with respect to an ac-
25 count beneficiary, amounts paid by such bene-

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

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

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

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

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

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

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

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

1 than a Medicare supplemental policy (as
2 defined in section 1882 of such Act).''.
3 (b) EFFECTIVE DATE.—The amendment made by
4 this section shall apply with respect to insurance pur-
5 chased after the date of the enactment of this Act in tax-
6 able years beginning after such date.

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

10 (a) IN GENERAL.—Paragraph (2) of section 223(d),
11 as amended by section 619, is amended by adding at the
12 end the following new subparagraph:
13 ''(D) CERTAIN MEDICAL EXPENSES IN-
14 CURRED BEFORE ESTABLISHMENT OF ACCOUNT
15 TREATED AS QUALIFIED.—An expense shall not
16 fail to be treated as a qualified medical expense
17 solely because such expense was incurred before
18 the establishment of the health savings account
19 if such expense was incurred—
20 ''(i) during either—
21 ''(I) the taxable year in which the
22 health savings account was estab-
23 lished, or
24 ''(II) the preceding taxable year
25 in the case of a health savings ac-

count established after the taxable year in which such expense was incurred but before the time prescribed by law for filing the return for such taxable year (not including extensions thereof), and

"(ii) for medical care of an individual during a period that such individual was covered by a high deductible health plan and met the requirements of subsection (c)(1)(A)(ii) (after application of subsection (c)(1)(B)).".

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

SEC. 521. PREVENTIVE CARE PRESCRIPTION DRUG CLARIFICATION.

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

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

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

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

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

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

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

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

1 "(D) EXCEPTION FOR ADMINISTRATIVE
2 ERRORS CORRECTED BEFORE DUE DATE OF RE-
3 TURN.—Subparagraph (A) shall not apply if
4 any payment or distribution is made to correct
5 an administrative, clerical or payroll contribu-
6 tion error and if—
7 "(i) such distribution is received by
8 the individual on or before the last day
9 prescribed by law (including extensions of
10 time) for filing such individual's return for
11 such taxable year, and
12 "(ii) such distribution is accompanied
13 by the amount of net income attributable
14 to such contribution.
15 Any net income described in clause (ii) shall be
16 included in the gross income of the individual
17 for the taxable year in which it is received.".
18 (b) EFFECTIVE DATE.—The amendment made by
19 this section shall take effect on the date of the enactment
20 of this Act.

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

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

1 (A) by striking paragraph (2) and insert-
2 ing the following:
3 "(2) INITIAL DEMONSTRATION.—The dem-
4 onstration program under this section shall begin 90
5 days after the date of the enactment of this para-
6 graph. The Secretary shall approve States to con-
7 duct demonstration programs under this section for
8 a 5-year period, with each State demonstration pro-
9 gram covering 1 or more geographic areas specified
10 by the State. With respect to a State, after the ini-
11 tial 5-year period of any demonstration program
12 conducted under this section by the State, unless the
13 Secretary finds, taking into account cost-effective-
14 ness and quality of care, that the State demonstra-
15 tion program has been unsuccessful, the demonstra-
16 tion program may be extended or made permanent
17 in the State."; and
18 (B) in paragraph (3), in the matter pre-
19 ceding subparagraph (A)—
20 (i) by striking "not"; and
21 (ii) by striking "unless" and inserting
22 "if";
23 (2) in subsection (b)—
24 (A) in paragraph (3), by inserting "clauses
25 (i) through (vii), (viii) (without regard to the

1 amendment made by section 2004(c)(2) of Pub-
2 lic Law 111–148), (x), or (xi) of'' after ''de-
3 scribed in''; and
4 (B) by striking paragraphs (4), (5), and
5 (6);
6 (3) in subsection (c)—
7 (A) by striking paragraphs (3) and (4);
8 (B) by redesignating paragraphs (5)
9 through (8) as paragraphs (3) through (6), re-
10 spectively; and
11 (C) in paragraph (4) (as redesignated by
12 subparagraph (B)), by striking ''Subject to sub-
13 paragraphs (D) and (E)'' and inserting ''Sub-
14 ject to subparagraph (D)''; and
15 (4) in subsection (d)—
16 (A) in paragraph (2), by striking subpara-
17 graph (E); and
18 (B) in paragraph (3)—
19 (i) in subparagraph (A)(ii), by strik-
20 ing ''Subject to subparagraph (B)(ii), in''
21 and inserting ''In''; and
22 (ii) by striking subparagraph (B) and
23 inserting the following:
24 ''(B) MAINTENANCE OF HEALTH OPPOR-
25 TUNITY ACCOUNT AFTER BECOMING INELI-

1 GIBLE FOR PUBLIC BENEFIT.—Notwithstanding
2 any other provision of law, if an account holder
3 of a health opportunity account becomes ineli-
4 gible for benefits under this title because of an
5 increase in income or assets—
6 "(i) no additional contribution shall be
7 made into the account under paragraph
8 (2)(A)(i); and
9 "(ii) the account shall remain avail-
10 able to the account holder for 3 years after
11 the date on which the individual becomes
12 ineligible for such benefits for withdrawals
13 under the same terms and conditions as if
14 the account holder remained eligible for
15 such benefits, and such withdrawals shall
16 be treated as medical assistance in accord-
17 ance with subsection (c)(4).".
18 (b) CONFORMING AMENDMENT.—Section 613 of
19 Public Law 111–3 is repealed.

Subtitle B—Other Provisions

SEC. 531. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL FITNESS PROGRAMS TREATED AS MEDICAL CARE.

(a) IN GENERAL.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(12) EXERCISE EQUIPMENT AND PHYSICAL FITNESS PROGRAMS.—

"(A) IN GENERAL.—The term 'medical care' shall include amounts paid—

"(i) to purchase or use equipment used in a program (including a self-directed program) of physical exercise,

"(ii) to participate, or receive instruction, in a program of physical exercise, and

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

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

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

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

6 (a) IN GENERAL.—Subsection (d) of section 213, as
7 amended by section 631, is amended by adding at the end
8 the following new paragraph:
9 "(13) NUTRITIONAL AND DIETARY SUPPLE-
10 MENTS.—
11 "(A) IN GENERAL.—The term 'medical
12 care' shall include amounts paid to purchase
13 herbs, vitamins, minerals, homeopathic rem-
14 edies, meal replacement products, and other di-
15 etary and nutritional supplements.
16 "(B) LIMITATION.—Amounts treated as
17 medical care under subparagraph (A) shall not
18 exceed $1,000 with respect to any individual for
19 any taxable year.
20 "(C) MEAL REPLACEMENT PRODUCT.—
21 For purposes of this paragraph, the term 'meal
22 replacement product' means any product that—
23 "(i) is permitted to bear labeling mak-
24 ing a claim described in section 403(r)(3)

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

"(ii) is permitted to claim under such section that such product is low in fat and is a good source of protein, fiber, and multiple essential vitamins and minerals.".

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

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

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

"(14) PERIODIC PROVIDER FEES.—The term 'medical care' shall include periodic fees paid to a primary physician, physician assistant, or nurse practitioner for the right to receive medical services on an as-needed basis.".

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

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

Subtitle A—Making Health Care Coverage Affordable for Every American

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

SEC. 601. ESTABLISH UNIVERSAL ACCESS PROGRAMS TO IMPROVE HIGH RISK POOLS AND REINSURANCE MARKETS.

(a) STATE REQUIREMENT.—

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

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

(i) a qualified State reinsurance program described in subsection (b); or

(ii) qualifying State high risk pool described in subsection (c)(1); and

1 (B) subject to paragraph (3), apply to the
2 operation of such a program from State funds
3 an amount equivalent to the portion of State
4 funds derived from State premium assessments
5 (as defined by the Secretary) that are not oth-
6 erwise used on State health care programs.
7 (2) RELATION TO CURRENT QUALIFIED HIGH
8 RISK POOL PROGRAM.—
9 (A) STATES NOT OPERATING A QUALIFIED
10 HIGH RISK POOL.—In the case of a State that
11 is not operating a current section 2745 quali-
12 fied high risk pool as of the date of the enact-
13 ment of this Act—
14 (i) the State may only meet the re-
15 quirement of paragraph (1) through the
16 operation of a qualified State reinsurance
17 program described in subsection (b); and
18 (ii) the State's operation of such a re-
19 insurance program shall be treated, for
20 purposes of section 2745 of the Public
21 Health Service Act, as the operation of a
22 qualified high risk pool described in such
23 section.
24 (B) STATE OPERATING A QUALIFIED HIGH
25 RISK POOL.—In the case of a State that is op-

1 erating a current section 2745 qualified high
2 risk pool as of the date of the enactment of this
3 Act—
4 (i) as of January 1, 2014, such a pool
5 shall not be treated as a qualified high risk
6 pool under section 2745 of the Public
7 Health Service Act unless the pool is a
8 qualifying State high risk pool described in
9 subsection (c)(1); and
10 (ii) the State may use premium as-
11 sessment funds described in paragraph
12 (1)(B) to transition from operation of such
13 a pool to operation of a qualified State re-
14 insurance program described in subsection
15 (b).
16 (3) APPLICATION OF FUNDS.—If the program
17 or pool operated under paragraph (1)(A) is in strong
18 fiscal health, as determined in accordance with
19 standards established by the National Association of
20 Insurance Commissioners and as approved by the
21 State Insurance Commissioner involved, the require-
22 ment of paragraph (1)(B) shall be deemed to be
23 met.
24 (b) QUALIFIED STATE REINSURANCE PROGRAM.—

1 (1) IN GENERAL.—For purposes of this section,
2 a "qualified State reinsurance program" means a
3 program operated by a State program that provides
4 reinsurance for health insurance coverage offered in
5 the small group market in accordance with the
6 model for such a program established (as of the date
7 of the enactment of this Act).
8 (2) FORM OF PROGRAM.—A qualified State re-
9 insurance program may provide reinsurance—
10 (A) on a prospective or retrospective basis;
11 and
12 (B) on a basis that protects health insur-
13 ance issuers against the annual aggregate
14 spending of their enrollees as well as purchase
15 protection against individual catastrophic costs.
16 (3) SATISFACTION OF HIPAA REQUIREMENT.—
17 A qualified State reinsurance program shall be
18 deemed, for purposes of section 2745 of the Public
19 Health Service Act, to be a qualified high risk pool
20 under such section.
21 (c) QUALIFYING STATE HIGH RISK POOL.—
22 (1) IN GENERAL.—A qualifying State high risk
23 pool described in this subsection means a current
24 section 2745 qualified high risk pool that meets the
25 following requirements:

1 (A) The pool must provide at least two
2 coverage options, one of which must be a high
3 deductible health plan coupled with a health
4 savings account.
5 (B) The pool must be funded with a stable
6 funding source.
7 (C) The pool must eliminate any waiting
8 lists so that all eligible residents who are seek-
9 ing coverage through the pool should be allowed
10 to receive coverage through the pool.
11 (D) The pool must allow for coverage of
12 individuals who, but for the 24-month disability
13 waiting period under section 226(b) of the So-
14 cial Security Act, would be eligible for Medicare
15 during the period of such waiting period.
16 (E) The pool must limit the pool premiums
17 to no more than 150 percent of the average
18 premium for applicable standard risk rates in
19 that State.
20 (F) The pool must conduct education and
21 outreach initiatives so that residents and bro-
22 kers understand that the pool is available to eli-
23 gible residents.

1 (G) The pool must provide coverage for
2 preventive services and disease management for
3 chronic diseases.
4 (2) VERIFICATION OF CITIZENSHIP OR ALIEN
5 QUALIFICATION.—
6 (A) IN GENERAL.—Notwithstanding any
7 other provision of law, only citizens and nation-
8 als of the United States shall be eligible to par-
9 ticipate in a qualifying State high risk pool that
10 receives funds under section 2745 of the Public
11 Health Service Act or this section.
12 (B) CONDITION OF PARTICIPATION.—As a
13 condition of a State receiving such funds, the
14 Secretary shall require the State to certify, to
15 the satisfaction of the Secretary, that such
16 State requires all applicants for coverage in the
17 qualifying State high risk pool to provide satis-
18 factory documentation of citizenship or nation-
19 ality in a manner consistent with section
20 1903(x) of the Social Security Act.
21 (C) RECORDS.—The Secretary shall keep
22 sufficient records such that a determination of
23 citizenship or nationality only has to be made
24 once for any individual under this paragraph.

1 (3) RELATION TO SECTION 2745.—As of Janu-
2 ary 1, 2014, a pool shall not qualify as qualified
3 high risk pool under section 2745 of the Public
4 Health Service Act unless the pool is a qualifying
5 State high risk pool described in paragraph (1).
6 (d) WAIVERS.—In order to accommodate new and in-
7 novative programs, the Secretary may waive such require-
8 ments of this section for qualified State reinsurance pro-
9 grams and for qualifying State high risk pools as the Sec-
10 retary deems appropriate.
11 (e) FUNDING.—In addition to any other amounts ap-
12 propriated, there is appropriated to carry out section 2745
13 of the Public Health Service Act (including through a pro-
14 gram or pool described in subsection (a)(1))—
15 (1) $15,000,000,000 for the period of fiscal
16 years 2014 through 2023; and
17 (2) an additional $10,000,000,000 for the pe-
18 riod of fiscal years 2019 through 2023.
19 (f) DEFINITIONS.—In this section:
20 (1) HEALTH INSURANCE COVERAGE; HEALTH
21 INSURANCE ISSUER.—The terms ''health insurance
22 coverage'' and ''health insurance issuer'' have the
23 meanings given such terms in section 2791 of the
24 Public Health Service Act.

1 (2) CURRENT SECTION 2745 QUALIFIED HIGH
2 RISK POOL.—The term ''current section 2745 quali-
3 fied high risk pool'' has the meaning given the term
4 ''qualified high risk pool'' under section 2745(g) of
5 the Public Health Service Act as in effect as of the
6 date of the enactment of this Act.
7 (3) SECRETARY.—The term ''Secretary'' means
8 the Secretary of Health and Human Services.
9 (4) STANDARD RISK RATE.—The term ''stand-
10 ard risk rate'' means a rate that—
11 (A) is determined under the State high
12 risk pool by considering the premium rates
13 charged by other health insurance issuers offer-
14 ing health insurance coverage to individuals in
15 the insurance market served;
16 (B) is established using reasonable actu-
17 arial techniques; and
18 (C) reflects anticipated claims experience
19 and expenses for the coverage involved.
20 (5) STATE.—The term ''State'' means any of
21 the 50 States or the District of Columbia.

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

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

7 (1) in paragraph (1)—

8 (A) by striking ''(1)(A)'' and inserting
9 ''(1)''; and

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

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

14 (3) in paragraph (3)—

15 (A) by striking ''(1)(A)'' and inserting
16 ''(1)''; and

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

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

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

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

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

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

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

SEC. 604. PREVENTING UNJUST CANCELLATION OF INSURANCE COVERAGE.

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

(1) in its heading, by inserting "**, CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,**" after "**GUARANTEED RENEWABILITY**";

(2) in subsection (a), by inserting ", including without rescission," after "continue in force"; and

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

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

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

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

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

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

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

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

12 SEC. 611. STATE INNOVATION PROGRAMS.

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

15 (1) PAYMENTS TO STATES.—

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

1 (i) bonus premium percentage (as de-
2 fined in paragraph (3)) for the State, mar-
3 ket, and year; and
4 (ii) the maximum State premium pay-
5 ment amount (as defined in paragraph (4))
6 for the State, market, and year.
7 (B) FOR PREMIUM REDUCTIONS IN THE
8 INDIVIDUAL MARKET.—If the Secretary deter-
9 mines that a State has reduced the average per
10 capita premium for health insurance coverage
11 in the individual market in year 3, in year 6,
12 or in year 9 below the premium baseline for
13 such year, the Secretary shall pay the State an
14 amount equal to the product of—
15 (i) bonus premium percentage for the
16 State, market, and year; and
17 (ii) the maximum State premium pay-
18 ment amount for the State, market, and
19 year.
20 (2) PREMIUM BASELINE.—For purposes of this
21 subsection, the term "premium baseline" means, for
22 a market in a State—
23 (A) for year 1, the average per capita pre-
24 miums for health insurance coverage in such
25 market in the State in such year; or

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

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

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

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

21 (3) BONUS PREMIUM PERCENTAGE DEFINED.—

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

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

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

5 (B) PREMIUM PERFORMANCE LEVEL.—For
6 purposes of this subsection, the term "premium
7 performance level" means, for a State, market,
8 and year, the percentage reduction in the aver-
9 age per capita premiums for health insurance
10 coverage for the State, market, and year, as
11 compared to the premium baseline for such
12 State, market, and year.
13 (4) MAXIMUM STATE PREMIUM PAYMENT
14 AMOUNT DEFINED.—For purposes of this sub-
15 section, the term "maximum State premium pay-
16 ment amount" means, for a State for the small

1 group market or the individual market for a year,
2 the product of—
3 (A) the proportion (as determined by the
4 Secretary), of the number of nonelderly individ-
5 uals lawfully residing in all the States who are
6 enrolled in health insurance coverage in the re-
7 spective market in the year, who are residents
8 of the State; and
9 (B) the amount available for obligation
10 from amounts appropriated under subsection
11 (d) for such market with respect to perform-
12 ance in such year.
13 (5) METHODOLOGY FOR CALCULATING AVER-
14 AGE PER CAPITA PREMIUMS.—
15 (A) ESTABLISHMENT.—The Secretary
16 shall establish, by rule and consistent with this
17 subsection, a methodology for computing the
18 average per capita premiums for health insur-
19 ance coverage for the small group market and
20 for the individual market in each State for each
21 year beginning with year 1.
22 (B) ADJUSTMENTS.—Under such method-
23 ology, the Secretary shall provide for the fol-
24 lowing adjustments (in a manner determined
25 appropriate by the Secretary):

1 (i) EXCLUSION OF ILLEGAL ALIENS.—
2 An adjustment so as not to take into ac-
3 count enrollees who are not lawfully
4 present in the United States and their pre-
5 mium costs.
6 (ii) TREATING STATE PREMIUM SUB-
7 SIDIES AS PREMIUM COSTS.—An adjust-
8 ment so as to increase per capita pre-
9 miums to remove the impact of premium
10 subsidies made directly by a State to re-
11 duce health insurance premiums.
12 (6) CONDITIONS OF PAYMENT.—As a condition
13 of receiving a payment under paragraph (1), a State
14 must agree to submit aggregate, non-individually
15 identifiable data to the Secretary, in a form and
16 manner specified by the Secretary, for use by the
17 Secretary to determine the State's premium baseline
18 and premium performance level for purposes of this
19 subsection.
20 (b) PROGRAMS THAT REDUCE THE NUMBER OF UN-
21 INSURED.—
22 (1) IN GENERAL.—If the Secretary determines
23 that a State has reduced the percentage of unin-
24 sured nonelderly residents in year 5, year 7, or year
25 9, below the uninsured baseline (as defined in para-

1 graph (2)) for the State for the year, the Secretary
2 shall pay the State an amount equal to the product
3 of—
4 (A) bonus uninsured percentage (as de-
5 fined in paragraph (3)) for the State and year;
6 and
7 (B) the maximum uninsured payment
8 amount (as defined in paragraph (4)) for the
9 State and year.
10 (2) UNINSURED BASELINE.—
11 (A) IN GENERAL.—For purposes of this
12 subsection, and subject to subparagraph (B),
13 the term "uninsured baseline" means, for a
14 State, the percentage of nonelderly residents in
15 the State who are uninsured in year 1.
16 (B) ADJUSTMENT.—The Secretary may, at
17 the written request of a State, adjust the unin-
18 sured baseline for States for a year to take into
19 account unanticipated and exceptional changes,
20 such as an unanticipated migration, of non-
21 elderly individuals into, or out of, States in a
22 manner that does not reflect substantially the
23 proportion of uninsured nonelderly residents in
24 the States involved in year 1. Any such adjust-
25 ment shall only be done in a manner that does

1 not result in the average of the uninsured base-
2 lines for nonelderly residents for all States
3 being changed.
4 (3) BONUS UNINSURED PERCENTAGE.—
5 (A) BONUS UNINSURED PERCENTAGE.—
6 For purposes of this subsection, the term
7 ''bonus uninsured percentage'' means, for a
8 State for a year, such percentage as determined
9 in accordance with the following table, based on
10 the uninsured performance level (as defined in
11 subparagraph (B)) for such State and year:

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

12 (B) UNINSURED PERFORMANCE LEVEL.—
13 For purposes of this subsection, the term ''un-
14 insured performance level'' means, for a State
15 for a year, the reduction (expressed as a per-
16 centage) in the percentage of uninsured non-
17 elderly residents in such State in the year as

1 compared to the uninsured baseline for such
2 State for such year.
3 (4) MAXIMUM STATE UNINSURED PAYMENT
4 AMOUNT DEFINED.—For purposes of this sub-
5 section, the term ''maximum State uninsured pay-
6 ment amount'' means, for a State for a year, the
7 product of—
8 (A) the proportion (as determined by the
9 Secretary), of the number of uninsured non-
10 elderly individuals lawfully residing in all the
11 States in the year, who are residents of the
12 State; and
13 (B) the amount available for obligation
14 under this subsection from amounts appro-
15 priated under subsection (d) with respect to
16 performance in such year.
17 (5) METHODOLOGY FOR COMPUTING THE PER-
18 CENTAGE OF UNINSURED NONELDERLY RESIDENTS
19 IN A STATE.—
20 (A) ESTABLISHMENT.—The Secretary
21 shall establish, by rule and consistent with this
22 subsection, a methodology for computing the
23 percentage of nonelderly residents in a State
24 who are uninsured in each year beginning with
25 year 1.

1 (B) RULES.—
2 (i) TREATMENT OF UNINSURED.—
3 Such methodology shall treat as uninsured
4 those residents who do not have health in-
5 surance coverage or other creditable cov-
6 erage (as defined in section 9801(c)(1) of
7 the Internal Revenue Code of 1986), ex-
8 cept that such methodology shall rely upon
9 data on the nonelderly and uninsured pop-
10 ulations within each State in such year
11 provided through population surveys con-
12 ducted by federal agencies.
13 (ii) LIMITATION TO NONELDERLY.—
14 Such methodology shall exclude individuals
15 who are 65 years of age or older.
16 (iii) EXCLUSION OF ILLEGAL
17 ALIENS.—Such methodology shall exclude
18 individuals not lawfully present in the
19 United States.
20 (6) CONDITIONS OF PAYMENT.—As a condition
21 of receiving a payment under paragraph (1), a State
22 must agree to submit aggregate, non-individually
23 identifiable data to the Secretary, in a form and
24 manner specified by the Secretary, for use by the
25 Secretary in determining the State's uninsured base-

1 line and uninsured performance level for purposes of
2 this subsection.
3 (c) DEFINITIONS.—For purposes of this section:
4 (1) GROUP HEALTH PLAN.—The term ‘‘group
5 health plan’’ has the meaning given such term in
6 section 9832(a) of the Internal Revenue Code of
7 1986.
8 (2) HEALTH INSURANCE COVERAGE.—The term
9 ‘‘health insurance coverage’’ has the meaning given
10 such term in section 9832(b)(1) of the Internal Rev-
11 enue Code of 1986.
12 (3) INDIVIDUAL MARKET.—Except as the Sec-
13 retary may otherwise provide in the case of group
14 health plans that have fewer than 2 participants as
15 current employees on the first day of a plan year,
16 the term ‘‘individual market’’ means the market for
17 health insurance coverage offered to individuals
18 other than in connection with a group health plan.
19 (4) SECRETARY.—The term ‘‘Secretary’’ means
20 the Secretary of Health and Human Services.
21 (5) SMALL GROUP MARKET.—The term ‘‘small
22 group market’’ means the market for health insur-
23 ance coverage under which individuals obtain health
24 insurance coverage (directly or through any arrange-
25 ment) on behalf of themselves (and their depend-

1 ents) through a group health plan maintained by an
2 employer who employed on average at least 2 but
3 not more than 50 employees on business days during
4 a calendar year.
5 (6) STATE.—The term "State" means any of
6 the 50 States and the District of Columbia.
7 (7) YEARS.—The terms "year 1", "year 2",
8 "year 3", and similar subsequently numbered years
9 mean 2014, 2015, 2016, and subsequent sequen-
10 tially numbered years.
11 (d) APPROPRIATIONS; PAYMENTS.—
12 (1) PAYMENTS FOR REDUCTIONS IN COST OF
13 HEALTH INSURANCE COVERAGE.—
14 (A) SMALL GROUP MARKET.—
15 (i) IN GENERAL.—From any funds in
16 the Treasury not otherwise appropriated,
17 there is appropriated for payments under
18 subsection (a)(1)(A)—
19 (I) $18,000,000,000 with respect
20 to performance in year 3;
21 (II) $5,000,000,000 with respect
22 to performance in year 6; and
23 (III) $2,000,000,000 with re-
24 spect to performance in year 9.

1 (ii) AVAILABILITY OF APPROPRIATED
2 FUNDS.—Funds appropriated under clause
3 (i) shall remain available until expended.
4 (B) INDIVIDUAL MARKET.—
5 (i) IN GENERAL.—Subject to clause
6 (ii), from any funds in the Treasury not
7 otherwise appropriated, there is appro-
8 priated for payments under subsection
9 (a)(1)(B)—
10 (I) $7,000,000,000 with respect
11 to performance in year 3;
12 (II) $2,000,000,000 with respect
13 to performance in year 6; and
14 (III) $1,000,000,000 with re-
15 spect to performance in year 9.
16 (ii) AVAILABILITY OF APPROPRIATED
17 FUNDS.—Of the funds appropriated under
18 clause (i) that are not expended or obli-
19 gated by the end of the year following the
20 year for which the funds are appro-
21 priated—
22 (I) 75 percent shall remain avail-
23 able until expended for payments
24 under subsection (a)(1)(B); and

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

(2) PAYMENTS FOR REDUCTIONS IN THE PERCENTAGE OF UNINSURED.—

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

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

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

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

(B) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under subparagraph (A) shall remain available until expended.

(3) PAYMENT TIMING.—Payments under this section shall be made in a form and manner specified by the Secretary in the year after the performance year involved.

SEC. 612. HEALTH PLAN FINDERS.

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

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

(b) MULTI-STATE PLAN FINDERS.—

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

(2) SHARING OF INFORMATION.—States shall regulate the manner in which data is shared between plan finders to ensure consistency and accuracy in the information about health insurance plans contained in such finders.

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

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

(2) The plan finder shall present complete information on the costs and benefits of health insurance plans (including information on monthly pre-

1 mium, copayments, and deductibles) in a uniform
2 manner that—
3 (A) uses the standard definitions developed
4 under paragraph (3); and
5 (B) is designed to allow consumers to eas-
6 ily compare such plans.
7 (3) The plan finder shall be available on the
8 Internet and accessible to all individuals in the State
9 or, in the case of a multi-State plan finder, in all
10 States covered by the multi-State plan finder.
11 (4) The plan finder shall allow consumers to
12 search and sort data on the health insurance plans
13 in the plan finder on criteria such as coverage of
14 specific benefits (such as coverage of disease man-
15 agement services or pediatric care services), as well
16 as data available on quality.
17 (5) The plan finder shall meet all relevant State
18 laws and regulations, including laws and regulations
19 related to the marketing of insurance products. In
20 the case of a multi-State plan finder, the finder shall
21 meet such laws and regulations for all of the States
22 involved.
23 (6) The plan finder shall meet solvency, finan-
24 cial, and privacy requirements established by the

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

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

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

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

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

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

1 (A) The health insurance plan shall be ac-
2 tuarially sound.
3 (B) The health insurance plan may not
4 have a history of abusive policy rescissions.
5 (C) The health insurance plan shall meet
6 financial and solvency requirements.
7 (D) The health insurance plan shall dis-
8 close—
9 (i) all financial arrangements involv-
10 ing the sale and purchase of health insur-
11 ance, such as the payment of fees and
12 commissions; and
13 (ii) such arrangements may not be
14 abusive.
15 (E) The health insurance plan shall main-
16 tain electronic health records that comply with
17 the requirements of the American Recovery and
18 Reinvestment Act of 2009 (Public Law 111–5)
19 related to electronic health records.
20 (F) The health insurance plan shall make
21 available to plan enrollees via the finder, wheth-
22 er by information provided to the finder or by
23 a website link directing the enrollee from the
24 finder to the health insurance plan website,
25 data that includes the price and cost to the in-

1 dividual of services offered by a provider according to the terms and conditions of the health plan. Data described in this paragraph is not made public by the finder, only made available to the individual once enrolled in the health plan.

(e) PROHIBITIONS.—

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

(2) CONFLICTS OF INTEREST.—

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

(i) be the private entity developing and maintaining a plan finder under subsections (a) and (b); or

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

(B) INDIVIDUALS.—An individual employed by a health insurance issuer offering a health insurance plan through a plan finder may not serve as a director or officer for—

(i) the private entity developing and maintaining a plan finder under subsections (a) and (b); or

(ii) the plan finder.

(f) CONSTRUCTION.—Nothing in this section shall be construed to allow the Secretary authority to regulate benefit packages or to prohibit health insurance brokers and agents from—

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

(2) marketing or offering health insurance products.

(g) PLAN FINDER DEFINED.—For purposes of this section, the term ''plan finder'' means a State plan finder under subsection (a) or a multi-State plan finder under subsection (b).

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

SEC. 613. ADMINISTRATIVE SIMPLIFICATION.

(a) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

1 "(9) OPERATING RULES.—The term 'operating
2 rules' means the necessary business rules and guide-
3 lines for the electronic exchange of information that
4 are not defined by a standard or its implementation
5 specifications as adopted for purposes of this part.".
6 (2) OPERATING RULES AND COMPLIANCE.—
7 Section 1173 of the Social Security Act (42 U.S.C.
8 1320d–2) is amended—
9 (A) in subsection (a)(2), by adding at the
10 end the following new subparagraph:
11 "(J) Electronic funds transfers."; and
12 (B) by adding at the end the following new
13 subsections:
14 "(g) OPERATING RULES.—
15 "(1) IN GENERAL.—The Secretary shall adopt
16 a single set of operating rules for each transaction
17 described in subsection (a)(2) with the goal of cre-
18 ating as much uniformity in the implementation of
19 the electronic standards as possible. Such operating
20 rules shall be consensus-based and reflect the nec-
21 essary business rules affecting health plans and
22 health care providers and the manner in which they
23 operate pursuant to standards issued under Health
24 Insurance Portability and Accountability Act of
25 1996.

1 "(2) OPERATING RULES DEVELOPMENT.—In
2 adopting operating rules under this subsection, the
3 Secretary shall rely on recommendations for oper-
4 ating rules developed by a qualified nonprofit entity,
5 as selected by the Secretary, that meets the fol-
6 lowing requirements:
7 "(A) The entity focuses its mission on ad-
8 ministrative simplification.
9 "(B) The entity demonstrates an estab-
10 lished multi-stakeholder and consensus-based
11 process for development of operating rules, in-
12 cluding representation by or participation from
13 health plans, health care providers, vendors, rel-
14 evant Federal agencies, and other standard de-
15 velopment organizations.
16 "(C) The entity has established a public
17 set of guiding principles that ensure the oper-
18 ating rules and process are open and trans-
19 parent.
20 "(D) The entity coordinates its activities
21 with the HIT Policy Committee and the HIT
22 Standards Committee (as established under
23 title XXX of the Public Health Service Act)
24 and complements the efforts of the Office of the

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

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

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

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

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

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

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

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

1 "(D) submit to the Secretary a rec-
2 ommendation as to whether the Secretary
3 should adopt such rules.
4 "(4) IMPLEMENTATION.—
5 "(A) IN GENERAL.—The Secretary shall
6 adopt operating rules under this subsection, by
7 regulation in accordance with subparagraph
8 (C), following consideration of the rules devel-
9 oped by the non-profit entity described in para-
10 graph (2) and the recommendation submitted
11 by the National Committee on Vital and Health
12 Statistics under paragraph (3)(D) and having
13 ensured consultation with providers.
14 "(B) ADOPTION REQUIREMENTS; EFFEC-
15 TIVE DATES.—
16 "(i) ELIGIBILITY FOR A HEALTH
17 PLAN AND HEALTH CLAIM STATUS.—The
18 set of operating rules for transactions for
19 eligibility for a health plan and health
20 claim status shall be adopted not later
21 than July 1, 2015, in a manner ensuring
22 that such rules are effective not later than
23 January 1, 2017, and may allow for the
24 use of a machine readable identification
25 card.

"(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice shall be adopted not later than July 1, 2016, in a manner ensuring that such rules are effective not later than January 1, 2018.

"(iii) OTHER COMPLETED TRANSACTIONS.—The set of operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, shall be adopted not later than July 1, 2018, in a manner ensuring that such rules are effective not later than January 1, 2020.

"(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital

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

6 "(h) COMPLIANCE.—

7 "(1) HEALTH PLAN CERTIFICATION.—

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

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

1 Secretary, in such form as the Secretary may
2 require, certifying that the data and informa-
3 tion systems for such plan are in compliance
4 with any applicable standards and operating
5 rules for the remainder of the completed trans-
6 actions described in subsection (a)(2), including
7 health claims or equivalent encounter informa-
8 tion, enrollment and disenrollment in a health
9 plan, health plan premium payments, and refer-
10 ral certification and authorization, respectively.
11 A health plan shall provide the same level of
12 documentation to certify compliance with such
13 transactions as is required to certify compliance
14 with the transactions specified in subparagraph
15 (A).
16 "(2) DOCUMENTATION OF COMPLIANCE.—A
17 health plan shall provide the Secretary, in such form
18 as the Secretary may require, with adequate docu-
19 mentation of compliance with the standards and op-
20 erating rules described under paragraph (1). A
21 health plan shall not be considered to have provided
22 adequate documentation and shall not be certified as
23 being in compliance with such standards, unless the
24 health plan—

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

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

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

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

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

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

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

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

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

21 "(2) EVALUATIONS AND REPORTS.—

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

1 review the existing standards and operating
2 rules established under this section.
3 ‘‘(B) REPORT.—Not later than July 1,
4 2018, and not less than biennially thereafter,
5 the review committee shall provide rec-
6 ommendations for updating and improving such
7 standards and rules. The review committee
8 shall recommend a single set of operating rules
9 per transaction standard and maintain the goal
10 of creating as much uniformity as possible in
11 the implementation of the electronic standards.
12 ‘‘(3) INTERIM FINAL RULEMAKING.—
13 ‘‘(A) IN GENERAL.—Any recommendations
14 to amend existing standards and operating
15 rules that have been approved by the review
16 committee and reported to the Secretary under
17 paragraph (2)(B) shall be adopted by the Sec-
18 retary through promulgation of an interim final
19 rule not later than 90 days after receipt of the
20 committee's report.
21 ‘‘(B) PUBLIC COMMENT.—
22 ‘‘(i) PUBLIC COMMENT PERIOD.—The
23 Secretary shall accept public comments on
24 any interim final rule published under this

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

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

10 "(4) REVIEW COMMITTEE.—

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

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

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

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

1 the National Coordinator for Health Informa-
2 tion Technology.
3 "(j) PENALTIES.—
4 "(1) PENALTY FEE.—
5 "(A) IN GENERAL.—Not later than April
6 1, 2018, and annually thereafter, the Secretary
7 shall assess a penalty fee (as determined under
8 subparagraph (B)) against a health plan that
9 has failed to meet the requirements under sub-
10 section (h) with respect to certification and doc-
11 umentation of compliance with the standards
12 (and their operating rules) as described under
13 paragraph (1) of such subsection.
14 "(B) FEE AMOUNT.—Subject to subpara-
15 graphs (C), (D), and (E), the Secretary shall
16 assess a penalty fee against a health plan in the
17 amount of $1 per covered life until certification
18 is complete. The penalty shall be assessed per
19 person covered by the plan for which its data
20 systems for major medical policies are not in
21 compliance and shall be imposed against the
22 health plan for each day that the plan is not in
23 compliance with the requirements under sub-
24 section (h).

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

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

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

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

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

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

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

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

19 "(4) COLLECTION OF PENALTY FEE.—

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

1 "(B) NOTICE.—Not later than August 1,
2 2018, and annually thereafter, the Secretary of
3 the Treasury shall provide notice to each health
4 plan that has been assessed a penalty fee by the
5 Secretary under this subsection. Such notice
6 shall include the amount of the penalty fee as-
7 sessed by the Secretary and the due date for
8 payment of such fee to the Secretary of the
9 Treasury (as described in subparagraph (C)).
10 "(C) PAYMENT DUE DATE.—Payment by a
11 health plan for a penalty fee assessed under
12 this subsection shall be made to the Secretary
13 of the Treasury not later than November 1,
14 2018, and annually thereafter.
15 "(D) UNPAID PENALTY FEES.—Any
16 amount of a penalty fee assessed against a
17 health plan under this subsection for which pay-
18 ment has not been made by the due date pro-
19 vided under subparagraph (C) shall be—
20 "(i) increased by the interest accrued
21 on such amount, as determined pursuant
22 to the underpayment rate established
23 under section 6601 of the Internal Rev-
24 enue Code of 1986; and

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

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

11 (b) PROMULGATION OF RULES.—

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

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

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

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

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

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

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

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

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

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

10 Subtitle B—Improving Access to 11 Health Care

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

15 SEC. 620. SHORT TITLE.

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

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

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

1 "PART 8—RULES GOVERNING ASSOCIATION
2 HEALTH PLANS

3 "SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

portation (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.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

"(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

1 "(2) RULES OF OPERATION AND FINANCIAL
2 CONTROLS.—The board of trustees has in effect
3 rules of operation and financial controls, based on a
4 3-year plan of operation, adequate to carry out the
5 terms of the plan and to meet all requirements of
6 this title applicable to the plan.
7 "(3) RULES GOVERNING RELATIONSHIP TO
8 PARTICIPATING EMPLOYERS AND TO CONTRAC-
9 TORS.—
10 "(A) BOARD MEMBERSHIP.—
11 "(i) IN GENERAL.—Except as pro-
12 vided in clauses (ii) and (iii), the members
13 of the board of trustees are individuals se-
14 lected from individuals who are the owners,
15 officers, directors, or employees of the par-
16 ticipating employers or who are partners in
17 the participating employers and actively
18 participate in the business.
19 "(ii) LIMITATION.—
20 "(I) GENERAL RULE.—Except as
21 provided in subclauses (II) and (III),
22 no such member is an owner, officer,
23 director, or employee of, or partner in,
24 a contract administrator or other
25 service provider to the plan.

1 "(II) LIMITED EXCEPTION FOR
2 PROVIDERS OF SERVICES SOLELY ON
3 BEHALF OF THE SPONSOR.—Officers
4 or employees of a sponsor which is a
5 service provider (other than a contract
6 administrator) to the plan may be
7 members of the board if they con-
8 stitute not more than 25 percent of
9 the membership of the board and they
10 do not provide services to the plan
11 other than on behalf of the sponsor.
12 "(III) TREATMENT OF PRO-
13 VIDERS OF MEDICAL CARE.—In the
14 case of a sponsor which is an associa-
15 tion whose membership consists pri-
16 marily of providers of medical care,
17 subclause (I) shall not apply in the
18 case of any service provider described
19 in subclause (I) who is a provider of
20 medical care under the plan.
21 "(iii) CERTAIN PLANS EXCLUDED.—
22 Clause (i) shall not apply to an association
23 health plan which is in existence on the
24 date of the enactment of the Small Busi-
25 ness Health Fairness Act of 2013.

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

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

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

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

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

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

"(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

"(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

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

"(A) active or retired owners (including self-employed individuals), officers, directors, or

employees of, or partners in, participating employers; or

"(B) the beneficiaries of individuals described in subparagraph (A).

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2013, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

"(1) the affiliated member was an affiliated member on the date of certification under this part; 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.

"(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage

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

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

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

19 "(2) upon request, any employer eligible to par-
20 ticipate is furnished information regarding all cov-
21 erage options available under the plan; and

22 "(3) the applicable requirements of sections
23 701, 702, and 703 are met with respect to the plan.

"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 include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

"(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

"(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

"(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in rela-

1 tion to employees of such employer or their
2 beneficiaries and do not vary on the basis of the
3 type of business or industry in which such em-
4 ployer is engaged.

5 "(B) Nothing in this title or any other pro-
6 vision of law shall be construed to preclude an
7 association health plan, or a health insurance
8 issuer offering health insurance coverage in
9 connection with an association health plan,
10 from—

11 "(i) setting contribution rates based
12 on the claims experience of the plan; or

13 "(ii) varying contribution rates for
14 small employers in a State to the extent
15 that such rates could vary using the same
16 methodology employed in such State for
17 regulating premium rates in the small
18 group market with respect to health insur-
19 ance coverage offered in connection with
20 bona fide associations (within the meaning
21 of section 2791(d)(3) of the Public Health
22 Service Act),

23 subject to the requirements of section 702(b)
24 relating to contribution rates.

"(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

"(4) MARKETING REQUIREMENTS.—

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

1 "(5) REGULATORY REQUIREMENTS.—Such
2 other requirements as the applicable authority deter-
3 mines are necessary to carry out the purposes of this
4 part, which shall be prescribed by the applicable au-
5 thority by regulation.

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

1 **"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
2 **FOR SOLVENCY FOR PLANS PROVIDING**
3 **HEALTH BENEFITS IN ADDITION TO HEALTH**
4 **INSURANCE COVERAGE.**

5 "(a) IN GENERAL.—The requirements of this section
6 are met with respect to an association health plan if—
7 "(1) the benefits under the plan consist solely
8 of health insurance coverage; or
9 "(2) if the plan provides any additional benefit
10 options which do not consist of health insurance cov-
11 erage, the plan—
12 "(A) establishes and maintains reserves
13 with respect to such additional benefit options,
14 in amounts recommended by the qualified actu-
15 ary, consisting of—
16 "(i) a reserve sufficient for unearned
17 contributions;
18 "(ii) a reserve sufficient for benefit li-
19 abilities which have been incurred, which
20 have not been satisfied, and for which risk
21 of loss has not yet been transferred, and
22 for expected administrative costs with re-
23 spect to such benefit liabilities;
24 "(iii) a reserve sufficient for any other
25 obligations of the plan; and

1 "(iv) a reserve sufficient for a margin
2 of error and other fluctuations, taking into
3 account the specific circumstances of the
4 plan; and
5 "(B) establishes and maintains aggregate
6 and specific excess/stop loss insurance and sol-
7 vency indemnification, with respect to such ad-
8 ditional benefit options for which risk of loss
9 has not yet been transferred, as follows:
10 "(i) The plan shall secure aggregate
11 excess/stop loss insurance for the plan with
12 an attachment point which is not greater
13 than 125 percent of expected gross annual
14 claims. The applicable authority may by
15 regulation provide for upward adjustments
16 in the amount of such percentage in speci-
17 fied circumstances in which the plan spe-
18 cifically provides for and maintains re-
19 serves in excess of the amounts required
20 under subparagraph (A).
21 "(ii) The plan shall secure specific ex-
22 cess/stop loss insurance for the plan with
23 an attachment point which is at least equal
24 to an amount recommended by the plan's
25 qualified actuary. The applicable authority

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

7 "(iii) The plan shall secure indem-
8 nification insurance for any claims which
9 the plan is unable to satisfy by reason of
10 a plan termination.

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

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

1 “(1) $500,000, or
2 “(2) such greater amount (but not greater than
3 $2,000,000) as may be set forth in regulations pre-
4 scribed by the applicable authority, considering the
5 level of aggregate and specific excess/stop loss insur-
6 ance provided with respect to such plan and other
7 factors related to solvency risk, such as the plan’s
8 projected levels of participation or claims, the nature
9 of the plan’s liabilities, and the types of assets avail-
10 able to assure that such liabilities are met.
11 “(c) ADDITIONAL REQUIREMENTS.—In the case of
12 any association health plan described in subsection (a)(2),
13 the applicable authority may provide such additional re-
14 quirements relating to reserves, excess/stop loss insurance,
15 and indemnification insurance as the applicable authority
16 considers appropriate. Such requirements may be provided
17 by regulation with respect to any such plan or any class
18 of such plans.
19 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-
20 ANCE.—The applicable authority may provide for adjust-
21 ments to the levels of reserves otherwise required under
22 subsections (a) and (b) with respect to any plan or class
23 of plans to take into account excess/stop loss insurance
24 provided with respect to such plan or plans.

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

20 "(f) MEASURES TO ENSURE CONTINUED PAYMENT
21 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

22 "(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
23 CIATION HEALTH PLAN FUND.—

24 "(A) IN GENERAL.—In the case of an as-
25 sociation health plan described in subsection

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

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

22 ‘‘(C) CONTINUED DUTY OF THE SEC-
23 RETARY.—The Secretary shall not cease to
24 carry out the provisions of paragraph (2) on ac-

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

1 ''(3) ASSOCIATION HEALTH PLAN FUND.—
2 ''(A) IN GENERAL.—There is established
3 on the books of the Treasury a fund to be
4 known as the 'Association Health Plan Fund'.
5 The Fund shall be available for making pay-
6 ments pursuant to paragraph (2). The Fund
7 shall be credited with payments received pursu-
8 ant to paragraph (1)(A), penalties received pur-
9 suant to paragraph (1)(B); and earnings on in-
10 vestments of amounts of the Fund under sub-
11 paragraph (B).
12 ''(B) INVESTMENT.—Whenever the Sec-
13 retary determines that the moneys of the fund
14 are in excess of current needs, the Secretary
15 may request the investment of such amounts as
16 the Secretary determines advisable by the Sec-
17 retary of the Treasury in obligations issued or
18 guaranteed by the United States.
19 ''(g) EXCESS/STOP LOSS INSURANCE.—For purposes
20 of this section—
21 ''(1) AGGREGATE EXCESS/STOP LOSS INSUR-
22 ANCE.—The term 'aggregate excess/stop loss insur-
23 ance' means, in connection with an association
24 health plan, a contract—

1 "(A) under which an insurer (meeting such
2 minimum standards as the applicable authority
3 may prescribe by regulation) provides for pay-
4 ment to the plan with respect to aggregate
5 claims under the plan in excess of an amount
6 or amounts specified in such contract;
7 "(B) which is guaranteed renewable; and
8 "(C) which allows for payment of pre-
9 miums by any third party on behalf of the in-
10 sured plan.
11 "(2) SPECIFIC EXCESS/STOP LOSS INSUR-
12 ANCE.—The term 'specific excess/stop loss insur-
13 ance' means, in connection with an association
14 health plan, a contract—
15 "(A) under which an insurer (meeting such
16 minimum standards as the applicable authority
17 may prescribe by regulation) provides for pay-
18 ment to the plan with respect to claims under
19 the plan in connection with a covered individual
20 in excess of an amount or amounts specified in
21 such contract in connection with such covered
22 individual;
23 "(B) which is guaranteed renewable; and

1 "(C) which allows for payment of premiums by any third party on behalf of the insured plan.

4 "(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

8 "(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

15 "(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

18 "(3) which allows for payment of premiums by any third party on behalf of the insured plan.

20 "(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

1 "(j) SOLVENCY STANDARDS WORKING GROUP.—
2 "(1) IN GENERAL.—Within 90 days after the
3 date of the enactment of the Small Business Health
4 Fairness Act of 2013, the applicable authority shall
5 establish a Solvency Standards Working Group. In
6 prescribing the initial regulations under this section,
7 the applicable authority shall take into account the
8 recommendations of such Working Group.
9 "(2) MEMBERSHIP.—The Working Group shall
10 consist of not more than 15 members appointed by
11 the applicable authority. The applicable authority
12 shall include among persons invited to membership
13 on the Working Group at least one of each of the
14 following:
15 "(A) a representative of the National Asso-
16 ciation of Insurance Commissioners;
17 "(B) a representative of the American
18 Academy of Actuaries;
19 "(C) a representative of the State govern-
20 ments, or their interests;
21 "(D) a representative of existing self-in-
22 sured arrangements, or their interests;
23 "(E) a representative of associations of the
24 type referred to in section 801(b)(1), or their
25 interests; and

1 "(F) a representative of multiemployer
2 plans that are group health plans, or their in-
3 terests.

4 **"SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
5 **LATED REQUIREMENTS.**

6 "(a) FILING FEE.—Under the procedure prescribed
7 pursuant to section 802(a), an association health plan
8 shall pay to the applicable authority at the time of filing
9 an application for certification under this part a filing fee
10 in the amount of $5,000, which shall be available in the
11 case of the Secretary, to the extent provided in appropria-
12 tion Acts, for the sole purpose of administering the certifi-
13 cation procedures applicable with respect to association
14 health plans.

15 "(b) INFORMATION TO BE INCLUDED IN APPLICA-
16 TION FOR CERTIFICATION.—An application for certifi-
17 cation under this part meets the requirements of this sec-
18 tion only if it includes, in a manner and form which shall
19 be prescribed by the applicable authority by regulation, at
20 least the following information:

21 "(1) IDENTIFYING INFORMATION.—The names
22 and addresses of—

23 "(A) the sponsor; and

24 "(B) the members of the board of trustees
25 of the plan.

1 “(2) STATES IN WHICH PLAN INTENDS TO DO
2 BUSINESS.—The States in which participants and
3 beneficiaries under the plan are to be located and
4 the number of them expected to be located in each
5 such State.
6 “(3) BONDING REQUIREMENTS.—Evidence pro-
7 vided by the board of trustees that the bonding re-
8 quirements of section 412 will be met as of the date
9 of the application or (if later) commencement of op-
10 erations.
11 “(4) PLAN DOCUMENTS.—A copy of the docu-
12 ments governing the plan (including any bylaws and
13 trust agreements), the summary plan description,
14 and other material describing the benefits that will
15 be provided to participants and beneficiaries under
16 the plan.
17 “(5) AGREEMENTS WITH SERVICE PRO-
18 VIDERS.—A copy of any agreements between the
19 plan and contract administrators and other service
20 providers.
21 “(6) FUNDING REPORT.—In the case of asso-
22 ciation health plans providing benefits options in ad-
23 dition to health insurance coverage, a report setting
24 forth information with respect to such additional
25 benefit options determined as of a date within the

1 120-day period ending with the date of the applica-
2 tion, including the following:
3 ‘‘(A) RESERVES.—A statement, certified
4 by the board of trustees of the plan, and a
5 statement of actuarial opinion, signed by a
6 qualified actuary, that all applicable require-
7 ments of section 806 are or will be met in ac-
8 cordance with regulations which the applicable
9 authority shall prescribe.
10 ‘‘(B) ADEQUACY OF CONTRIBUTION
11 RATES.—A statement of actuarial opinion,
12 signed by a qualified actuary, which sets forth
13 a description of the extent to which contribution
14 rates are adequate to provide for the payment
15 of all obligations and the maintenance of re-
16 quired reserves under the plan for the 12-
17 month period beginning with such date within
18 such 120-day period, taking into account the
19 expected coverage and experience of the plan. If
20 the contribution rates are not fully adequate,
21 the statement of actuarial opinion shall indicate
22 the extent to which the rates are inadequate
23 and the changes needed to ensure adequacy.
24 ‘‘(C) CURRENT AND PROJECTED VALUE OF
25 ASSETS AND LIABILITIES.—A statement of ac-

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

"(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

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

"(3) submits such plan in writing to the applicable authority.

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

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than

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

1 "(b) MANDATORY TERMINATION.—In any case in
2 which—
3 "(1) the applicable authority has been notified
4 under subsection (a) (or by an issuer of excess/stop
5 loss insurance or indemnity insurance pursuant to
6 section 806(a)) of a failure of an association health
7 plan which is or has been certified under this part
8 and is described in section 806(a)(2) to meet the re-
9 quirements of section 806 and has not been notified
10 by the board of trustees of the plan that corrective
11 action has restored compliance with such require-
12 ments; and
13 "(2) the applicable authority determines that
14 there is a reasonable expectation that the plan will
15 continue to fail to meet the requirements of section
16 806,
17 the board of trustees of the plan shall, at the direction
18 of the applicable authority, terminate the plan and, in the
19 course of the termination, take such actions as the appli-
20 cable authority may require, including satisfying any
21 claims referred to in section 806(a)(2)(B)(iii) and recov-
22 ering for the plan any liability under subsection
23 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
24 that the affairs of the plan will be, to the maximum extent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 "(1) the sponsor and plan administrator;

25 "(2) each participant;

1 “(3) each participating employer; and
2 “(4) if applicable, each employee organization
3 which, for purposes of collective bargaining, rep-
4 resents plan participants.
5 “(d) ADDITIONAL DUTIES.—Except to the extent in-
6 consistent with the provisions of this title, or as may be
7 otherwise ordered by the court, the Secretary, upon ap-
8 pointment as trustee under this section, shall be subject
9 to the same duties as those of a trustee under section 704
10 of title 11, United States Code, and shall have the duties
11 of a fiduciary for purposes of this title.
12 “(e) OTHER PROCEEDINGS.—An application by the
13 Secretary under this subsection may be filed notwith-
14 standing the pendency in the same or any other court of
15 any bankruptcy, mortgage foreclosure, or equity receiver-
16 ship proceeding, or any proceeding to reorganize, conserve,
17 or liquidate such plan or its property, or any proceeding
18 to enforce a lien against property of the plan.
19 “(f) JURISDICTION OF COURT.—
20 “(1) IN GENERAL.—Upon the filing of an appli-
21 cation for the appointment as trustee or the issuance
22 of a decree under this section, the court to which the
23 application is made shall have exclusive jurisdiction
24 of the plan involved and its property wherever lo-
25 cated with the powers, to the extent consistent with

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

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

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

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

8 ''(a) IN GENERAL.—Notwithstanding section 514, a 9 State may impose by law a contribution tax on an associa-10 tion health plan described in section 806(a)(2), if the plan 11 commenced operations in such State after the date of the 12 enactment of the Small Business Health Fairness Act of 13 2013.

14 ''(b) CONTRIBUTION TAX.—For purposes of this sec-15 tion, the term 'contribution tax' imposed by a State on 16 an association health plan means any tax imposed by such 17 State if—

18 ''(1) such tax is computed by applying a rate to 19 the amount of premiums or contributions, with re-20 spect to individuals covered under the plan who are 21 residents of such State, which are received by the 22 plan from participating employers located in such 23 State or from such individuals;

24 ''(2) the rate of such tax does not exceed the 25 rate of any tax imposed by such State on premiums

1 or contributions received by insurers or health main-
2 tenance organizations for health insurance coverage
3 offered in such State in connection with a group
4 health plan;

5 ‘‘(3) such tax is otherwise nondiscriminatory;
6 and

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

19 **‘‘SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

20 ‘‘(a) DEFINITIONS.—For purposes of this part—

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

1 "(2) MEDICAL CARE.—The term 'medical care'
2 has the meaning provided in section 733(a)(2).
3 "(3) HEALTH INSURANCE COVERAGE.—The
4 term 'health insurance coverage' has the meaning
5 provided in section 733(b)(1).
6 "(4) HEALTH INSURANCE ISSUER.—The term
7 'health insurance issuer' has the meaning provided
8 in section 733(b)(2).
9 "(5) APPLICABLE AUTHORITY.—The term 'ap-
10 plicable authority' means the Secretary, except that,
11 in connection with any exercise of the Secretary's
12 authority regarding which the Secretary is required
13 under section 506(d) to consult with a State, such
14 term means the Secretary, in consultation with such
15 State.
16 "(6) HEALTH STATUS-RELATED FACTOR.—The
17 term 'health status-related factor' has the meaning
18 provided in section 733(d)(2).
19 "(7) INDIVIDUAL MARKET.—
20 "(A) IN GENERAL.—The term 'individual
21 market' means the market for health insurance
22 coverage offered to individuals other than in
23 connection with a group health plan.
24 "(B) TREATMENT OF VERY SMALL
25 GROUPS.—

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

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

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

1 partner, or self-employed individual in relation to the
2 plan.
3 "(9) APPLICABLE STATE AUTHORITY.—The
4 term 'applicable State authority' means, with respect
5 to a health insurance issuer in a State, the State in-
6 surance commissioner or official or officials des-
7 ignated by the State to enforce the requirements of
8 title XXVII of the Public Health Service Act for the
9 State involved with respect to such issuer.
10 "(10) QUALIFIED ACTUARY.—The term 'quali-
11 fied actuary' means an individual who is a member
12 of the American Academy of Actuaries.
13 "(11) AFFILIATED MEMBER.—The term 'affili-
14 ated member' means, in connection with a sponsor—
15 "(A) a person who is otherwise eligible to
16 be a member of the sponsor but who elects an
17 affiliated status with the sponsor,
18 "(B) in the case of a sponsor with mem-
19 bers which consist of associations, a person who
20 is a member of any such association and elects
21 an affiliated status with the sponsor, or
22 "(C) in the case of an association health
23 plan in existence on the date of the enactment
24 of the Small Business Health Fairness Act of

1 2013, a person eligible to be a member of the
2 sponsor or one of its member associations.
3 "(12) LARGE EMPLOYER.—The term 'large em-
4 ployer' means, in connection with a group health
5 plan with respect to a plan year, an employer who
6 employed an average of at least 51 employees on
7 business days during the preceding calendar year
8 and who employs at least 2 employees on the first
9 day of the plan year.
10 "(13) SMALL EMPLOYER.—The term 'small em-
11 ployer' means, in connection with a group health
12 plan with respect to a plan year, an employer who
13 is not a large employer.
14 "(b) RULES OF CONSTRUCTION.—
15 "(1) EMPLOYERS AND EMPLOYEES.—For pur-
16 poses of determining whether a plan, fund, or pro-
17 gram is an employee welfare benefit plan which is an
18 association health plan, and for purposes of applying
19 this title in connection with such plan, fund, or pro-
20 gram so determined to be such an employee welfare
21 benefit plan—
22 "(A) in the case of a partnership, the term
23 'employer' (as defined in section 3(5)) includes
24 the partnership in relation to the partners, and
25 the term 'employee' (as defined in section 3(6))

1 includes any partner in relation to the partner-
2 ship; and

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

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

21 (b) CONFORMING AMENDMENTS TO PREEMPTION
22 RULES.—

23 (1) Section 514(b)(6) of such Act (29 U.S.C.
24 1144(b)(6)) is amended by adding at the end the
25 following new subparagraph:

1 "(E) The preceding subparagraphs of this paragraph
2 do not apply with respect to any State law in the case
3 of an association health plan which is certified under part
4 8.".

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

7 (A) in subsection (b)(4), by striking "Sub-
8 section (a)" and inserting "Subsections (a) and
9 (d)";

10 (B) in subsection (b)(5), by striking "sub-
11 section (a)" in subparagraph (A) and inserting
12 "subsection (a) of this section and subsections
13 (a)(2)(B) and (b) of section 805", and by strik-
14 ing "subsection (a)" in subparagraph (B) and
15 inserting "subsection (a) of this section or sub-
16 section (a)(2)(B) or (b) of section 805";

17 (C) by redesignating subsections (d) and
18 (e) as subsections (e) and (f), respectively; and

19 (D) by inserting after subsection (c) the
20 following new subsection:

21 "(d)(1) Except as provided in subsection (b)(4), the
22 provisions of this title shall supersede any and all State
23 laws insofar as they may now or hereafter preclude, or
24 have the effect of precluding, a health insurance issuer
25 from offering health insurance coverage in connection with

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

3 ''(2) Except as provided in paragraphs (4) and (5)
4 of subsection (b) of this section—

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

17 ''(B) In any case in which health insurance cov-
18 erage of any policy type is offered in a State under
19 an association health plan certified under part 8 and
20 the filing, with the applicable State authority (as de-
21 fined in section 812(a)(9)), of the policy form in
22 connection with such policy type is approved by such
23 State authority, the provisions of this title shall su-
24 persede any and all laws of any other State in which
25 health insurance coverage of such type is offered, in-

1 sofar as they may preclude, upon the filing in the
2 same form and manner of such policy form with the
3 applicable State authority in such other State, the
4 approval of the filing in such other State.

5 ''(3) Nothing in subsection (b)(6)(E) or the preceding
6 provisions of this subsection shall be construed, with re-
7 spect to health insurance issuers or health insurance cov-
8 erage, to supersede or impair the law of any State—

9 ''(A) providing solvency standards or similar
10 standards regarding the adequacy of insurer capital,
11 surplus, reserves, or contributions, or

12 ''(B) relating to prompt payment of claims.

13 ''(4) For additional provisions relating to association
14 health plans, see subsections (a)(2)(B) and (b) of section
15 805.

16 ''(5) For purposes of this subsection, the term 'asso-
17 ciation health plan' has the meaning provided in section
18 801(a), and the terms 'health insurance coverage', 'par-
19 ticipating employer', and 'health insurance issuer' have
20 the meanings provided such terms in section 812, respec-
21 tively.''.

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

24 (A) in clause (i)(II), by striking ''and'' at
25 the end;

1 (B) in clause (ii), by inserting ‘‘and which
2 does not provide medical care (within the mean-
3 ing of section 733(a)(2)),’’ after ‘‘arrange-
4 ment,’’ and by striking ‘‘title.’’ and inserting
5 ‘‘title, and’’; and
6 (C) by adding at the end the following new
7 clause:
8 ‘‘(iii) subject to subparagraph (E), in the case
9 of any other employee welfare benefit plan which is
10 a multiple employer welfare arrangement and which
11 provides medical care (within the meaning of section
12 733(a)(2)), any law of any State which regulates in-
13 surance may apply.’’.
14 (4) Section 514(e) of such Act (as redesignated
15 by paragraph (2)(C)) is amended—
16 (A) by striking ‘‘Nothing’’ and inserting
17 ‘‘(1) Except as provided in paragraph (2), noth-
18 ing’’; and
19 (B) by adding at the end the following new
20 paragraph:
21 ‘‘(2) Nothing in any other provision of law enacted
22 on or after the date of the enactment of the Small Busi-
23 ness Health Fairness Act of 2013 shall be construed to
24 alter, amend, modify, invalidate, impair, or supersede any

1 provision of this title, except by specific cross-reference to
2 the affected section.''.

3 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
4 (29 U.S.C. 102(16)(B)) is amended by adding at the end
5 the following new sentence: ''Such term also includes a
6 person serving as the sponsor of an association health plan
7 under part 8.''.

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

17 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is
18 amended by inserting ''or part 8'' after ''this part''.

19 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
20 CATION OF SELF-INSURED ASSOCIATION HEALTH
21 PLANS.—Not later than January 1, 2016, the Secretary
22 of Labor shall report to the Committee on Education and
23 the Workforce of the House of Representatives and the
24 Committee on Health, Education, Labor, and Pensions of

1 the Senate the effect association health plans have had,
2 if any, on reducing the number of uninsured individuals.

3 (g) CLERICAL AMENDMENT.—The table of contents
4 in section 1 of the Employee Retirement Income Security
5 Act of 1974 is amended by inserting after the item relat-
6 ing to section 734 the following new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"801. Association health plans.
"802. Certification of association health plans.
"803. Requirements relating to sponsors and boards of trustees.
"804. Participation and coverage requirements.
"805. Other requirements relating to plan documents, contribution rates, and benefit options.
"806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
"807. Requirements for application and related requirements.
"808. Notice requirements for voluntary termination.
"809. Corrective actions and mandatory termination.
"810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
"811. State assessment authority.
"812. Definitions and rules of construction.".

7 **SEC. 622. CLARIFICATION OF TREATMENT OF SINGLE EM-**
8 **PLOYER ARRANGEMENTS.**

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

12 (1) in clause (i), by inserting after "control
13 group," the following: "except that, in any case in
14 which the benefit referred to in subparagraph (A)
15 consists of medical care (as defined in section
16 812(a)(2)), two or more trades or businesses, wheth-
17 er or not incorporated, shall be deemed a single em-

1 ployer for any plan year of such plan, or any fiscal
2 year of such other arrangement, if such trades or
3 businesses are within the same control group during
4 such year or at any time during the preceding 1-year
5 period,'';

6 (2) in clause (iii), by striking ''(iii) the deter-
7 mination'' and inserting the following:

8 ''(iii)(I) in any case in which the benefit re-
9 ferred to in subparagraph (A) consists of medical
10 care (as defined in section 812(a)(2)), the deter-
11 mination of whether a trade or business is under
12 'common control' with another trade or business
13 shall be determined under regulations of the Sec-
14 retary applying principles consistent and coextensive
15 with the principles applied in determining whether
16 employees of two or more trades or businesses are
17 treated as employed by a single employer under sec-
18 tion 4001(b), except that, for purposes of this para-
19 graph, an interest of greater than 25 percent may
20 not be required as the minimum interest necessary
21 for common control, or

22 ''(II) in any other case, the determination'';

23 (3) by redesignating clauses (iv) and (v) as
24 clauses (v) and (vi), respectively; and

1 (4) by inserting after clause (iii) the following
2 new clause:
3 ''(iv) in any case in which the benefit referred
4 to in subparagraph (A) consists of medical care (as
5 defined in section 812(a)(2)), in determining, after
6 the application of clause (i), whether benefits are
7 provided to employees of two or more employers, the
8 arrangement shall be treated as having only one par-
9 ticipating employer if, after the application of clause
10 (i), the number of individuals who are employees and
11 former employees of any one participating employer
12 and who are covered under the arrangement is
13 greater than 75 percent of the aggregate number of
14 all individuals who are employees or former employ-
15 ees of participating employers and who are covered
16 under the arrangement,''.

17 **SEC. 623. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
18 **CIATION HEALTH PLANS.**

19 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
20 MISREPRESENTATIONS.—Section 501 of the Employee
21 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
22 is amended—
23 (1) by inserting ''(a)'' after ''Sec. 501.''; and
24 (2) by adding at the end the following new sub-
25 section:

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

7 ''(1) being an association health plan which has
8 been certified under part 8;

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

19 ''(3) being a plan or arrangement described in
20 section 3(40)(A)(i),

21 shall, upon conviction, be imprisoned not more than 5
22 years, be fined under title 18, United States Code, or
23 both.''.

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

4 ''(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
5 SIST ORDERS.—

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

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

18 ''(B) is an association health plan certified
19 under part 8 and is not operating in accordance
20 with the requirements under part 8 for such
21 certification,

22 a district court of the United States shall enter an
23 order requiring that the plan or arrangement cease
24 activities.

1 “(2) EXCEPTION.—Paragraph (1) shall not
2 apply in the case of an association health plan or
3 other arrangement if the plan or arrangement shows
4 that—
5 “(A) all benefits under it referred to in
6 paragraph (1) consist of health insurance cov-
7 erage; and
8 “(B) with respect to each State in which
9 the plan or arrangement offers or provides ben-
10 efits, the plan or arrangement is operating in
11 accordance with applicable State laws that are
12 not superseded under section 514.
13 “(3) ADDITIONAL EQUITABLE RELIEF.—The
14 court may grant such additional equitable relief, in-
15 cluding any relief available under this title, as it
16 deems necessary to protect the interests of the pub-
17 lic and of persons having claims for benefits against
18 the plan.”.
19 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
20 Section 503 of such Act (29 U.S.C. 1133) is amended by
21 inserting “(a) IN GENERAL.—” before “In accordance”,
22 and by adding at the end the following new subsection:
23 “(b) ASSOCIATION HEALTH PLANS.—The terms of
24 each association health plan which is or has been certified
25 under part 8 shall require the board of trustees or the

1 named fiduciary (as applicable) to ensure that the require-
2 ments of this section are met in connection with claims
3 filed under the plan.''.

4 **SEC. 624. COOPERATION BETWEEN FEDERAL AND STATE**
5 **AUTHORITIES.**

6 Section 506 of the Employee Retirement Income Se-
7 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
8 at the end the following new subsection:

9 ''(d) CONSULTATION WITH STATES WITH RESPECT
10 TO ASSOCIATION HEALTH PLANS.—

11 ''(1) AGREEMENTS WITH STATES.—The Sec-
12 retary shall consult with the State recognized under
13 paragraph (2) with respect to an association health
14 plan regarding the exercise of—

15 ''(A) the Secretary's authority under sec-
16 tions 502 and 504 to enforce the requirements
17 for certification under part 8; and

18 ''(B) the Secretary's authority to certify
19 association health plans under part 8 in accord-
20 ance with regulations of the Secretary applica-
21 ble to certification under part 8.

22 ''(2) RECOGNITION OF PRIMARY DOMICILE
23 STATE.—In carrying out paragraph (1), the Sec-
24 retary shall ensure that only one State will be recog-
25 nized, with respect to any particular association

1 health plan, as the State with which consultation is
2 required. In carrying out this paragraph—
3 "(A) in the case of a plan which provides
4 health insurance coverage (as defined in section
5 812(a)(3)), such State shall be the State with
6 which filing and approval of a policy type of-
7 fered by the plan was initially obtained, and
8 "(B) in any other case, the Secretary shall
9 take into account the places of residence of the
10 participants and beneficiaries under the plan
11 and the State in which the trust is main-
12 tained.".

13 **SEC. 625. EFFECTIVE DATE AND TRANSITIONAL AND**
14 **OTHER RULES.**

15 (a) EFFECTIVE DATE.—The amendments made by
16 this chapter shall take effect 1 year after the date of the
17 enactment of this Act. The Secretary of Labor shall first
18 issue all regulations necessary to carry out the amend-
19 ments made by this chapter within 1 year after the date
20 of the enactment of this Act.

21 (b) TREATMENT OF CERTAIN EXISTING HEALTH
22 BENEFITS PROGRAMS.—
23 (1) IN GENERAL.—In any case in which, as of
24 the date of the enactment of this Act, an arrange-
25 ment is maintained in a State for the purpose of

1 providing benefits consisting of medical care for the
2 employees and beneficiaries of its participating em-
3 ployers, at least 200 participating employers make
4 contributions to such arrangement, such arrange-
5 ment has been in existence for at least 10 years, and
6 such arrangement is licensed under the laws of one
7 or more States to provide such benefits to its par-
8 ticipating employers, upon the filing with the appli-
9 cable authority (as defined in section 812(a)(5) of
10 the Employee Retirement Income Security Act of
11 1974 (as amended by this chapter)) by the arrange-
12 ment of an application for certification of the ar-
13 rangement under part 8 of subtitle B of title I of
14 such Act—
15 (A) such arrangement shall be deemed to
16 be a group health plan for purposes of title I
17 of such Act;
18 (B) the requirements of sections 801(a)
19 and 803(a) of the Employee Retirement Income
20 Security Act of 1974 shall be deemed met with
21 respect to such arrangement;
22 (C) the requirements of section 803(b) of
23 such Act shall be deemed met, if the arrange-
24 ment is operated by a board of directors
25 which—

1 (i) is elected by the participating em-
2 ployers, with each employer having one
3 vote; and
4 (ii) has complete fiscal control over
5 the arrangement and which is responsible
6 for all operations of the arrangement;
7 (D) the requirements of section 804(a) of
8 such Act shall be deemed met with respect to
9 such arrangement; and
10 (E) the arrangement may be certified by
11 any applicable authority with respect to its op-
12 erations in any State only if it operates in such
13 State on the date of certification.
14 The provisions of this subsection shall cease to apply
15 with respect to any such arrangement at such time
16 after the date of the enactment of this Act as the
17 applicable requirements of this subsection are not
18 met with respect to such arrangement.
19 (2) DEFINITIONS.—For purposes of this sub-
20 section, the terms ''group health plan'', ''medical
21 care'', and ''participating employer'' shall have the
22 meanings provided in section 812 of the Employee
23 Retirement Income Security Act of 1974, except
24 that the reference in paragraph (7) of such section
25 to an ''association health plan'' shall be deemed a

reference to an arrangement referred to in this subsection.

CHAPTER 2—TARGETED EFFORTS TO EXPAND ACCESS

SEC. 631. EXTENDING COVERAGE OF DEPENDENTS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 714 the following new section:

"SEC. 715. EXTENDING COVERAGE OF DEPENDENTS.

"(a) IN GENERAL.—In the case of a group health plan, or health insurance coverage offered in connection with a group health plan, that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan or coverage shall continue to treat the individual as a dependent child without regard to the individual's age through at least the end of the plan year in which the individual turns an age specified in the plan, but not less than 23 years of age.

"(b) CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan to provide benefits for dependent children as beneficiaries under the

1 plan or to require a participant to elect coverage of de-
2 pendent children.''.

3 (2) CLERICAL AMENDMENT.—The table of con-
4 tents of such Act is amended by inserting after the
5 item relating to section 714 the following new item:

``Sec. 715. Extending coverage of dependents.''.

6 (b) PHSA.—Title XXVII of the Public Health Serv-
7 ice Act is amended by inserting after section 2707 the fol-
8 lowing new section:

9 **``SEC. 2708. EXTENDING COVERAGE OF DEPENDENTS.**

10 ``(a) IN GENERAL.—In the case of a group health
11 plan, or health insurance coverage offered in connection
12 with a group health plan, that treats as a beneficiary
13 under the plan an individual who is a dependent child of
14 a participant or beneficiary under the plan, the plan or
15 coverage shall continue to treat the individual as a depend-
16 ent child without regard to the individual's age through
17 at least the end of the plan year in which the individual
18 turns an age specified in the plan, but not less than 23
19 years of age.

20 ``(b) CONSTRUCTION.—Nothing in this section shall
21 be construed as requiring a group health plan to provide
22 benefits for dependent children as beneficiaries under the
23 plan or to require a participant to elect coverage of de-
24 pendent children.''.

25 (c) IRC.—

1 (1) IN GENERAL.—Subchapter B of chapter
2 100 of the Internal Revenue Code of 1986 is amend-
3 ed by adding at the end the following new section:

4 **"SEC. 9814. EXTENDING COVERAGE OF DEPENDENTS.**

5 "(a) IN GENERAL.—In the case of a group health
6 plan that treats as a beneficiary under the plan an indi-
7 vidual who is a dependent child of a participant or bene-
8 ficiary under the plan, the plan shall continue to treat the
9 individual as a dependent child without regard to the indi-
10 vidual's age through at least the end of the plan year in
11 which the individual turns an age specified in the plan,
12 but not less than 23 years of age.

13 "(b) CONSTRUCTION.—Nothing in this section shall
14 be construed as requiring a group health plan to provide
15 coverage for dependent children as beneficiaries under the
16 plan or to require a participant to elect coverage of de-
17 pendent children.".

18 (2) CLERICAL AMENDMENT.—The table of sec-
19 tions in such subchapter is amended by adding at
20 the end the following new item:

"Sec. 9814. Extending coverage of dependents.".

21 (d) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to group health plans for plan
23 years beginning more than 3 months after the date of the
24 enactment of this Act and shall apply to individuals who
25 are dependent children under a group health plan, or

1 health insurance coverage offered in connection with such
2 a plan, on or after such date.

3 **SEC. 632. ALLOWING AUTO-ENROLLMENT FOR EMPLOYER**
4 **SPONSORED COVERAGE.**

5 (a) IN GENERAL.—No State shall establish a law
6 that prevents an employer from instituting auto-enroll-
7 ment for coverage of a participant or beneficiary, including
8 current employees, under a group health plan, or health
9 insurance coverage offered in connection with such a plan,
10 so long as the participant or beneficiary has the option
11 of declining such coverage.

12 (b) AUTO-ENROLLMENT.—

13 (1) NOTICE REQUIRED.—Employers with auto-
14 enrollment under a group health plan or health in-
15 surance coverage shall provide annual notification,
16 within a reasonable period before the beginning of
17 each plan year, to each employee eligible to partici-
18 pate in the plan. The notice shall explain the em-
19 ployee contribution to such plan and the employee's
20 right to decline coverage.

21 (2) TREATMENT OF NON-ACTION.—After a rea-
22 sonable period of time after receipt of the notice, if
23 an employee fails to make an affirmative declaration
24 declining coverage, then such an employee may be

enrolled in the group health plan or health insurance coverage offered in connection with such a plan.''.

(c) CONSTRUCTION.—Nothing in this section shall be construed to supersede State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll or the sponsoring of employer sponsored health insurance coverage except to the extent that such standard or requirement prevents an employer from instituting the auto-enrollment described in subsection (a).

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

SEC. 701. INCREASED CIVIL MONEY PENALTIES AND CRIMINAL FINES FOR MEDICARE FRAUD AND ABUSE.

(a) INCREASED CIVIL MONEY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (a), in the matter following paragraph (10)—

(A) by striking ''$10,000'' each place it appears and inserting ''$20,000'';

1 (B) by striking ‘‘$15,000’’ and inserting
2 ‘‘$30,000’’; and
3 (C) by striking ‘‘$50,000’’ each place it ap-
4 pears and inserting ‘‘$100,000’’; and
5 (2) in subsection (b)—
6 (A) in paragraph (1), in the flush matter
7 following subparagraph (B), by striking
8 ‘‘$2,000’’ and inserting ‘‘$4,000’’;
9 (B) in paragraph (2), by striking ‘‘$2,000’’
10 and inserting ‘‘$4,000’’; and
11 (C) in paragraph (3)(A)(i), by striking
12 ‘‘$5,000’’ and inserting ‘‘$10,000’’.
13 (b) INCREASED CRIMINAL FINES.—Section 1128B of
14 the Social Security Act (42 U.S.C. 1320a–7b) is amend-
15 ed—
16 (1) in subsection (a), in the flush matter fol-
17 lowing paragraph (6)—
18 (A) by striking ‘‘$25,000’’ and inserting
19 ‘‘$100,000’’; and
20 (B) by striking ‘‘$10,000’’ and inserting
21 ‘‘$20,000’’;
22 (2) in subsection (b)—
23 (A) in paragraph (1), in the flush matter
24 following subparagraph (B), by striking
25 ‘‘$25,000’’ and inserting ‘‘$100,000’’; and

1 (B) in paragraph (2), in the flush matter
2 following subparagraph (B), by striking
3 "$25,000" and inserting "$100,000";
4 (3) in subsection (c), by striking "$25,000" and
5 inserting "$100,000";
6 (4) in subsection (d), in the second flush matter
7 following subparagraph (B), by striking "$25,000"
8 and inserting "$100,000"; and
9 (5) in subsection (e), by striking "$2,000" and
10 inserting "$4,000".
11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to civil money penalties and fines
13 imposed for actions taken on or after the date of enact-
14 ment of this Act.

15 **SEC. 702. INCREASED SENTENCES FOR FELONIES INVOLV-**
16 **ING MEDICARE FRAUD AND ABUSE.**

17 (a) FALSE STATEMENTS AND REPRESENTATIONS.—
18 Section 1128B(a) of the Social Security Act (42 U.S.C.
19 1320a–7b(a)) is amended, in clause (i) of the flush matter
20 following paragraph (6), by striking "not more than five
21 years" and inserting "not more than 10 years".
22 (b) ANTI-KICKBACK.—Section 1128B(b) of the So-
23 cial Security Act (42 U.S.C. 1320a–7b(b)) is amended—
24 (1) in paragraph (1), in the flush matter fol-
25 lowing subparagraph (B), by striking "not more

than five years'' and inserting ''not more than 10 years''; and

(2) in paragraph (2), in the flush matter following subparagraph (B), by striking ''not more than five years'' and inserting ''not more than 10 years''.

(c) FALSE STATEMENT OR REPRESENTATION WITH RESPECT TO CONDITIONS OR OPERATIONS OF FACILITIES.—Section 1128B(c) of the Social Security Act (42 U.S.C. 1320a–7b(c)) is amended by striking ''not more than five years'' and inserting ''not more than 10 years''.

(d) EXCESS CHARGES.—Section 1128B(d) of the Social Security Act (42 U.S.C. 1320a–7b(d)) is amended, in the second flush matter following subparagraph (B), by striking ''not more than five years'' and inserting ''not more than 10 years''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to criminal penalties imposed for actions taken on or after the date of enactment of this Act.

SEC. 703. OTHER DME SUPPLIER ANTI-FRAUD AND ABUSE PROVISIONS.

(a) MANDATORY PERIODIC SITE INSPECTIONS FOR DME SUPPLIERS.—The Secretary of Health and Human Services shall require, as a condition for participation of

1 suppliers of durable medical equipment under part B of
2 title XVIII of the Social Security Act—
3 (1) a site inspection to be conducted for each
4 such supplier that has not previously participated
5 under such part within 6 months of the date of its
6 initial participation under such part; and
7 (2) a site inspection at least every 2 years to
8 be conducted for each such supplier that has pre-
9 viously participated under such part.
10 (b) POST-PAYMENT REVIEW.—The Secretary also
11 shall provide conduct post-payment reviews of claims for
12 items and services furnished under such part by durable
13 medical equipment suppliers that begin participation
14 under such part after the date of the enactment of this
15 Act. Such reviews shall be conducted not less often than
16 after the first 6, 12, and 18 months of such participation.
17 (c) AVAILABILITY OF FUNDS.—Funds in the Health
18 Care Fraud and Abuse Control Account under section
19 1817(k) of the Social Security Act (42 U.S.C. 1395i(k))
20 shall be available for the conduct of site inspections and
21 post-payment review required under this section.
22 (d) TREATMENT OF SKILLED NURSING FACILI-
23 TIES.—In this section, a skilled nursing facility shall not
24 be treated as a supplier of durable medical equipment with
25 respect to any individual who is a resident of such facility.

SEC. 704. RETENTION OF CERTAIN FRAUD AND ABUSE PROVISIONS.

Section 101 shall not apply to the provisions (including amendments made by) title VI of Public Law 111–148, other than subtitles D, H, and I of such title, and provisions of Public Law 111–152 insofar as they relate to such provisions.

SEC. 705. ENSURING TIMELY ENFORCEMENT OF MEDICARE SECONDARY PAYER REQUIREMENTS IN LIABILITY CASES.

The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall affirmatively establish, for initial implementation not later than 90 days after the date of the enactment of this Act, a plan to require applicable plans (as defined in subparagraph (F) of section 1862(b)(8) of the Social Security Act (42 U.S.C. 1395y(b)(8)), as added by section 111(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173)), to meet the determination and submission requirements under subparagraph (A) of such section 1862(b)(8).

○