115TH CONGRESS
1ST SESSION

S. 222

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

IN THE SENATE OF THE UNITED STATES

JANUARY 24, 2017

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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Obamacare Replacement Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—REPEALS

SEC. 101. REPEAL OF INDIVIDUAL AND EMPLOYER MANDATES.

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

''(h) TERMINATION.—This section shall not apply with respect to any month beginning after the date of enactment of the Obamacare Replacement Act.''.

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

''(e) TERMINATION.—This section shall not apply with respect to any month beginning after the date of enactment of the Obamacare Replacement Act.''.

SEC. 102. REPEAL OF PUBLIC HEALTH SERVICE ACT PROVISIONS.

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 are repealed:

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

(2) Section 2702 (42 U.S.C. 300gg–1).

(3) Section 2703 (42 U.S.C. 300gg–2).

(4) Section 2704 (42 U.S.C. 300gg–3).

(5) Section 2705 (42 U.S.C. 300gg–4).

(6) Section 2707 (42 U.S.C. 300gg–6).

(7) Section 2708 (42 U.S.C. 300gg–7).

(8) Section 2711 (42 U.S.C. 300gg–11).

(9) Section 2712 (42 U.S.C. 300gg–12).

(10) Section 2713 (42 U.S.C. 300gg–13).

(11) Section 2715 (42 U.S.C. 300gg–15).

(12) Section 2715A (42 U.S.C. 300gg–15a).

(13) Section 2716 (42 U.S.C. 300gg–16).

(14) Section 2718 (42 U.S.C. 300gg–18).

(15) Section 2719 (42 U.S.C. 300gg–19).

(16) Section 2719A (42 U.S.C. 300gg–19a).

(17) Section 2794 (42 U.S.C. 300gg–94), relating to ensuring that consumers get value for their dollars.

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

(c) REDESIGNATIONS AND TRANSFERS.—The following provisions of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) shall be redesignated and transferred as follows:

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

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

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

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

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

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

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

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

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

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

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the repeals under subsection (a) shall take effect on the date of enactment of this Act and shall apply to plan years beginning after such date of enactment.

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

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

SEC. 103. REPEAL OF PATIENT PROTECTION AND AFFORDABLE CARE ACT PROVISIONS.

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

(b) REPEAL OF 3-MONTH GRACE PERIOD FOR NONPAYMENT PREMIUMS.—Clause (iv) of section 1412(c)(2)(B) of the Patient Protection and Affordable Care Act is amended by striking ''nonpayment of premiums by the insured'' and all that follows and inserting ''nonpayment of premiums by the insured, notify the Secretary of such nonpayment.''.

(c) EFFECTIVE DATE.—This section, and the amendments made by this section, shall take effect on the date of enactment of this Act and shall apply to plan years and taxable years beginning after such date of enactment.

SEC. 104. CONFORMING AND TECHNICAL AMENDMENTS.

(a) PHSA PROVISIONS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in section 2724(c) (42 U.S.C. 300gg–23(c)), by striking ''(other than section 2704)'' and inserting ''(other than section 2725)'';

(2) in section 2741(b)(3) (42 U.S.C. 300gg–41(a)(3)), by striking ''2712'' and inserting ''2707'';

(3) in section 2751(a) (42 U.S.C. 300gg–51(a)), by striking ''2704'' and inserting ''2725'';

(4) in section 2752 (42 U.S.C. 300gg–52), by striking ''2706'' and inserting ''2727''; and

(5) in section 2753 (42 U.S.C. 300gg–54), relating to coverage of dependent students on medically necessary leave of absence, by striking ''2707'' and inserting ''2728''.

(b) PPACA PROVISIONS.—The Patient Protection and Affordable Care Act (Public Law 111–148) is amended—

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

(A) by striking ''the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act),''; and

(B) by striking ''and be consistent with the standards adopted for the uniform explanation

of coverage as provided for in section 2715 of the Public Health Service Act'';

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

''(3) APPLICATION OF CERTAIN PROVISIONS.—Section 2711 of the Public Health Service Act (relating to extension of dependent coverage) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply.'';

(3) in section 1301(a)(4) (42 U.S.C. 18021(a)(4)), by striking ''section 2701(a)(2) of the Public Health Service Act'' and inserting ''section 2701(a)(2) of the Public Health Service Act as in effect on the day before the date of enactment of the Obamacare Replacement Act or as determined by the Secretary'';

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

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

(A) in subsection (c)—

(i) in paragraph (1)(B), by striking ''(in a manner consistent with applicable

network adequacy provisions under section 2702(c) of the Public Health Service Act)''; and

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

(B) in subsection (d)(4)(E), by striking '', including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act'';

(C) in subsection (e)(2), by striking '', and the information and the recommendations'' and all that follows through ''premium increases),''; and

(D) in subsection (f)(2)(B), by inserting before the period ''as in effect on the day before the date of enactment of the Obamacare Replacement Act or as determined by the Secretary''; and

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

(c) ERISA PROVISIONS.—Section 715 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d) is amended—

(1) in subsection (a)—

(A) by striking ''(a) GENERAL RULE'' and all that follows through ''the provisions of part A'' in paragraph (1) and inserting ''The provisions of part A''; and

(B) by striking ''as if included in this subpart; and'' in paragraph (1) and all that follows through ''to the extent that'' in paragraph (2) and inserting ''as if included in this subpart. To the extent that''; and

(2) by striking subsection (b).

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

(1) in section 36B(b)(3)(C)—

(A) in the first sentence, by striking ''and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act''; and

(B) by striking the second sentence;

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

(3) in section 9815—

(A) in subsection (a)—

(i) by striking ''(a) GENERAL RULE'' and all that follows through ''the provisions of part A'' in paragraph (1) and inserting ''The provisions of part A''; and

(ii) by striking ''as if included in this subpart; and'' in paragraph (1) and all that follows through ''to the extent that'' in paragraph (2) and inserting ''as if included in this subpart. To the extent that''; and

(B) by striking subsection (b).

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

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

TITLE II—TAXATION REFORM

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

SEC. 201. TAX DEDUCTION FOR HEALTH INSURANCE PREMIUMS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 224 as section 225 and by inserting after section 222 the following new section:

"SEC. 224. HEALTH INSURANCE PREMIUMS.

"(a) IN GENERAL.—There shall be allowed as a deduction the amount of premiums paid by the taxpayer for health insurance coverage (as defined in section 9832) of the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of the taxpayer.

"(b) COORDINATION PROVISIONS.—

"(1) PREMIUM ASSISTANCE CREDIT.—Subsection (a) shall not apply with respect to so much of any premium for which a credit has been allowed under section 36B.

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

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

''(3) DEDUCTION FOR MEDICAL EXPENSES.—For purposes of determining the amount of the deduction under section 213, any amount for which a deduction is allowed under subsection (a) shall not be treated as an expense paid for medical care.''.

(b) DEDUCTION AVAILABLE ABOVE THE LINE.—Section 62(a) of the Internal Revenue Code of 1986 is amended by inserting after paragraph (21) the following new paragraph:

''(22) HEALTH INSURANCE PREMIUMS.—The deduction allowed by section 224.''.

(c) CONFORMING AMENDMENTS.—

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

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

(3) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by redesignating the item relating to section 224 as relating to section 225 and by inserting after the item relating to section 223 the following new item:

''Sec. 224. Health insurance premiums.''.

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

SEC. 202. REFUNDABLE TAX CREDIT FOR PAYROLL TAXES ATTRIBUTABLE TO HEALTH INSURANCE PREMIUMS.

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

"SEC. 36C. REFUND OF PAYROLL TAXES ATTRIBUTABLE TO HEALTH INSURANCE PREMIUMS.

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the applicable percentage of the premiums paid by the taxpayer for health insurance coverage (as defined in section 9832) of the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of the taxpayer.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the term 'applicable percentage' means the percentage equal to the sum of the rates of in effect under subsections (a) and (b) of section 3101.

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

''(1) the social security taxes (as defined in section 24(d)) of the taxpayer for the taxable year, reduced by

''(2) the sum of the credits allowed under section 24(d) and 32 for the taxable year.''.

(b) CONFORMING AMENDMENTS.—

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

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

''Sec. 36C. Refund of payroll taxes attributable to health insurance premiums.''.

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

Subtitle B—Health Savings Accounts

SEC. 211. REPEAL OF CONTRIBUTION LIMITATIONS.

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

''(b) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.''.

(b) CONFORMING AMENDMENTS.—

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

(A) by striking ''subsection (f)(5)'' and inserting ''subsection (f)(4)'', and

(B) by striking ''accepted—'' and all that follows and inserting ''accepted unless it is in cash.''.

(2) Subsection (f) of section 223 of such Code is amended by striking paragraph (3) and by redesignating paragraphs (4) through (8) as paragraphs (3) through (7), respectively.

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

(A) by striking ''subsections (b)(2) and (c)(2)(A)'' both places it appears and inserting ''subsection (c)(2)(A)'', and

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

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins determined by substituting 'calendar year 2003' for 'calendar year 1992'.".

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

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

(B) by striking "223(f)(4)" in subparagraph (U) and inserting "223(f)(3)".

(5) Paragraph (1) of section 106(d) of such Code is amended by striking "under an accident or health plan" and all that follows and inserting "under an accident or health plan.".

(6) Subparagraph (C) of section 106(e)(4) of such Code is amended by striking "223(f)(5)" and inserting "223(f)(4)".

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

(A) by striking "LIMITATIONS.—" in the heading and all that follows through "(ii) ONE-TIME TRANSFER.—" in clause (ii), and inserting "ONE-TIME TRANSFER.—",

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

(C) by striking ''subclause (II)'' in clause (i), as so redesignated, and inserting ''clause (ii)''.

(8) Section 4973 of such Code is amended by striking subsection (g) and by redesignating subsection (h) as subsection (g).

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

SEC. 212. FREEDOM FROM MANDATE.

(a) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986, as amended by section 211, is further amended by striking subsections (c) and (g) and by redesignating subsections (d), (e), (f), and (h) as subsections (c), (d), (e), and (f), respectively.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 223 of the Internal Revenue Code of 1986 is amended to read as follows:

''(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid

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

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

(3) Subparagraph (U) of section 26(b)(2) of such Code, as amended by section 211, is further amended by striking ''section 223(f)(3)'' and inserting ''section 223(e)(3)''.

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

(5) Section 106(d)(1) of such Code is amended—

(A) by striking ''who is an eligible individual (as defined in section 223(c)(1))'', and

(B) by striking ''section 223(d)'' and inserting ''section 223(c)''.

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

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

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

''(3) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(e)(4).'', and

(C) by striking ''to any eligible individual covered under a high deductible health plan of the employer'' in paragraph (4)(B)(ii) (as so redesignated) and inserting ''to any employee with respect to whom a health savings account has been established''.

(7) Section 408(d)(9)(A) of such Code is amended by striking ''who is an eligible individual (as defined in section 223(c)) and''.

(8) Section 877A(g)(6) of such Code is amended by striking ''223(f)(4)'' and inserting ''223(e)(4)''.

(9) Section 4975 of such Code is amended—

(A) in subsection (c)(6)—

(i) by striking ''section 223(d)'' and inserting ''section 223(c)'', and

(ii) by striking ''section 223(e)(2)'' and inserting ''section 223(d)(2)'', and

(B) in subsection (e)(1)(E), by striking ''section 223(d)'' and inserting ''section 223(e)''.

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

''(b) RULES AND REQUIREMENTS.—

''(1) IN GENERAL.—An employer meets the requirements of this subsection for any calendar year if the employer makes available comparable contributions to the health savings accounts of all comparable participating employees for each coverage period during such calendar year.

''(2) COMPARABLE CONTRIBUTIONS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'comparable contributions' means contributions—

''(i) which are the same amount, or

''(ii) if the employees are covered by a health plan, which are the same percentage of the annual deductible limit under the plan covering the employees.

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

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

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

''(4) PART-TIME EMPLOYEES.—

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

''(B) PART-TIME EMPLOYEE.—For purposes of subparagraph (A), the term 'part-time employee' means any employee who is customarily employed for fewer than 30 hours per week.''.

(11) Section 4980G(d) of such Code is amended by striking ''section 4980E'' and inserting ''this section''.

(12) Section 6693(a)(2)(C) of such Code is amended by striking ''section 223(h)'' and inserting ''section 223(f)''.

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

SEC. 213. ALLOWANCE OF DISTRIBUTIONS FOR PRESCRIPTION AND OVER-THE-COUNTER MEDICINES AND DRUGS.

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

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

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

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

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

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid in taxable years beginning after the date of the enactment of this Act.

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

SEC. 214. PURCHASE OF HEALTH INSURANCE FROM HSA.

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

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

ther amended by striking ''and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual'' and inserting ''any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, and any child (as defined in section 152(f)(1)) of such individual who has not attained the age of 27 before the end of such individual's taxable year''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years beginning after such date.

SEC. 215. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.

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

''(B) CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS QUALIFIED.—An expense shall not fail to be treated as a qualified medical expense

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

"(i) during either—

"(I) the taxable year in which the health savings account was established, or

"(II) the preceding taxable year, in the case of a health savings account 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 which (but for the fact that it was incurred before the establishment of the account) otherwise meets the requirements of the preceding subparagraphs.".

(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. 216. ADMINISTRATIVE ERROR CORRECTION BEFORE DUE DATE OF RETURN.

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

''(D) EXCEPTION FOR ADMINISTRATIVE ERRORS CORRECTED BEFORE DUE DATE OF RETURN.—Subparagraph (A) shall not apply if any payment or distribution is made to correct an administrative, clerical, or payroll contribution error and if—

''(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(ii) such distribution is accompanied by the amount of net income attributable to such contribution.

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

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

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

(a) IN GENERAL.—Paragraph (7)(A) of section 223(e) of the Internal Revenue Code of 1986, as redesignated by the preceding sections of this subtitle, is amended—

(1) by inserting ", child, parent, or grandparent" after "surviving spouse",

(2) by inserting ", child, parent, or grandparent, as the case may be," after "the spouse",

(3) by inserting ", CHILD, PARENT, OR GRANDPARENT" after "SPOUSE" in the heading thereof, and

(4) by adding at the end the following: "In the case of a child who acquires such beneficiary's interest and with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins, such health savings account shall be treated as a health savings account of such child.".

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

SEC. 218. CREDIT FOR CONTRIBUTIONS TO AN HSA.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 25D the following new section:

"SEC. 25E. CONTRIBUTIONS TO A HEALTH SAVINGS ACCOUNT.

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

"(b) QUALIFIED HSA CONTRIBUTION.—

"(1) IN GENERAL.—For purposes of this section, the term 'qualified HSA contribution' means an amount paid in cash during the taxable year by or on behalf of an individual to a health savings account (as defined in section 223(c)) of such individual.

"(2) EXCEPTION FOR AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—The amount taken into account as qualified HSA contributions of the individual under paragraph (1) for a taxable year shall be reduced by the amount of any distribution from such health savings account during such

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

''(c) COORDINATION WITH DEDUCTION.—For coordination rule, see section 223(b)(1).''.

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

''Sec. 25E. Contributions to a health savings account.''.

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

''(b) SPECIAL RULES.—

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

''(2) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another

taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.''.

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

SEC. 219. EQUIVALENT BANKRUPTCY PROTECTIONS FOR HEALTH SAVINGS ACCOUNTS AS RETIREMENT FUNDS.

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

''(r) TREATMENT OF HEALTH SAVINGS ACCOUNTS.—For purposes of this section, any health savings account (as described in section 223 of the Internal Revenue Code of 1986) shall be treated in the same manner as an individual retirement account described in section 408 of such Code.''.

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

Subtitle C—Medical Expenses

SEC. 221. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL FITNESS PROGRAMS TREATED AS MEDICAL CARE.

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

''(12) EXERCISE EQUIPMENT AND PHYSICAL FITNESS ACTIVITY.—

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

''(i) for equipment for use in a program (including a self-directed program) of physical exercise or physical activity,

''(ii) to participate, or receive instruction, in a program of physical exercise, nutrition, or health coaching (including a self-directed program), and

''(iii) for membership at a fitness facility.

''(B) OVERALL DOLLAR LIMITATION.—

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

''(ii) EXCEPTION.—Clause (i) shall not apply for purposes of determining whether expenses reimbursed through a health flexible spending arrangement subject to section 125(i)(1) are incurred for medical care.

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

''(i) if such equipment is utilized exclusively for participation in fitness, exercise, sport, or other physical activity programs,

''(ii) if such equipment is not apparel or footwear, and

''(iii) in the case of any item of sports equipment (other than exercise equipment), to the extent the amount paid for such item does not exceed $250.

''(D) FITNESS FACILITY.—For purposes of subparagraph (A)(iii), the term 'fitness facility' means a facility—

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

ties for the preservation, maintenance, encouragement, or development of physical fitness, or serves as the site of such a program of a State or local government,

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

"(iii) which does not offer golf, hunting, sailing, or riding facilities,

"(iv) whose health or fitness facility is not incidental to its overall function and purpose, and

"(v) which is fully compliant with the State of jurisdiction and Federal anti-discrimination laws.".

(b) LIMITATION NOT TO APPLY FOR CERTAIN PURPOSES.—

(1) HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) of section 223(c)(2) of the Internal Revenue Code of 1986, as amended and redesignated by subtitle B, is further amended by inserting ", determined without regard to paragraph (12)(B) thereof)" after "medical care (as defined in section 213(d)".

(2) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of

1986, as amended by subtitle B, is further amended by inserting ", determined without regard to paragraph (12)(B) thereof" after "medical care (as defined in section 213(d)".

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

SEC. 222. CERTAIN NUTRITIONAL AND DIETARY SUPPLEMENTS TO BE TREATED AS MEDICAL CARE.

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

"(13) NUTRITIONAL AND DIETARY SUPPLEMENTS.—

"(A) IN GENERAL.—The term 'medical care' shall include amounts paid to purchase herbs, vitamins, minerals, homeopathic remedies, meal replacement products, and other dietary and nutritional supplements.

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

''(C) MEAL REPLACEMENT PRODUCT.—For purposes of this paragraph, the term 'meal replacement product' means any product that—

''(i) is permitted to bear labeling making 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.

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

(b) LIMITATION NOT TO APPLY FOR CERTAIN PURPOSES.—

(1) HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) of section 223(c)(2) of the Internal Revenue Code of 1986, as amended and redesignated by this Act, is amended by striking ''paragraph (12)(B)'' and inserting ''paragraphs (12)(B) and (13)(B)''.

(2) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2), as amended by this Act, is amended by striking ''paragraph (12)(B)'' and inserting ''paragraphs (12)(B) and (13)(B)''.

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

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

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

''(14) PERIODIC PROVIDER FEES.—The term 'medical care' shall include—

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

''(B) pre-paid primary care services designed to screen for, diagnose, cure, mitigate, treat, or prevent disease and promote wellness.''.

(b) EXCEPTION FOR FLEXIBLE SPENDING ACCOUNTS.—Section 125 of the Internal Revenue Code of

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

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

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

SEC. 224. CLARIFICATION OF TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MEDICAL CARE.

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

''(15) TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS.—Capitated primary care payments shall be treated as amounts paid for medical care.''.

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

Subtitle D—Miscellaneous

SEC. 231. CONTRIBUTIONS OF MEDICARE BENEFICIARIES PARTICIPATING IN MEDICARE ADVANTAGE MSA.

(a) IN GENERAL.—Section 138(b) of the Internal Revenue Code of 1986 is amended by striking paragraph (2) and by redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(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. 232. PHYSICIAN CHARITY AND UNCOMPENSATED CARE DEDUCTION.

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED CARE.

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

''(1) the amount such physician would have otherwise charged for qualified charity care provided by such physician during such taxable year, and

''(2) the amount of any debt owed to such physician for physicians' services which becomes worthless during such taxable year.

''(b) DEFINITIONS.—For purposes of this section—

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

''(2) QUALIFIED CHARITY CARE.—The term 'qualified charity care' means physicians' services provided on a volunteer or pro bono basis (not including any services for which an amount was charged but not paid).

''(3) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).

''(c) LIMITATIONS.—

''(1) SERVICE CHARGE LIMITATION.—The amount determined under subsection (a) with respect to any services or debt—

''(A) shall be reduced by any reimbursement received by the physician for such services or debt, and

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

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

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

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

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

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

''Sec. 199A. Physician charity and uncompensated care.''.

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

TITLE III—INDIVIDUAL HEALTH INSURANCE REFORM

SEC. 301. POOL REFORM FOR INDIVIDUAL MEMBERSHIP EXPANSION.

The Public Health Service Act is amended by inserting after title XXXIII the following new title:

''TITLE XXXIV—POOL REFORM FOR INDIVIDUAL MEMBERSHIP EXPANSION

''SEC. 3400. PURPOSE.

''The purpose of this title is to provide, through the establishment of independent health pools (referred to in this title as 'IHP'), for the reform of, and expansion of enrollment in, health insurance coverage for individuals and small employers.

"SEC. 3401. DEFINITION OF INDEPENDENT HEALTH POOL.

''(a) IN GENERAL.—For purposes of this title, the terms 'individual health pool' and 'IHP' mean a legal nonprofit entity that meets the following requirements:

''(1) ORGANIZATION.—The IHP—

''(A) has been formed and maintained in good faith for a purpose that includes the formation of a risk pool in order to offer health insurance coverage to its members;

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

''(C) does not make health insurance coverage offered through the IHP available other than in connection with a member of the IHP;

''(D) is not a health insurance issuer; and

''(E) does not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals, or employees of employers, in any health insurance coverage, except in conjunction with services offered through the IHP.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

"(A) DIFFERENT GROUPS.—The IHP, in conjunction with those health insurance issuers that offer health benefits coverage through the IHP, makes available health benefits coverage in the manner described in subsection (b) to all members of the IHP and the dependents of such members (and, in the case of small employers, employees and their dependents) in the manner described in subsection (c)(2) at rates that are established by the health insurance issuer on a policy or product specific basis and that may vary for individuals covered through an IHP.

"(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

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

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

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

''(C) NO ASSUMPTION OF INSURANCE RISK BY IHP.—The IHP provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

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

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—The IHP may provide administrative services for members. Such services may include accounting, billing, and enrollment information.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Except as provided in section 3402, any health benefits coverage offered through an IHP—

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

''(B) shall be approved or otherwise permitted to be offered under State law; and

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

''(2) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through an IHP from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the IHP and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) MEMBERS.—

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

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

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

"SEC. 3402. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

"(a) PREEMPTION OF STATE LAWS RESTRICTING FORMATION OF IHPS.—Any State law or regulation relating to the composition or organization of an IHP is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

"(b) PREEMPTION OF STATE REQUIREMENTS RELATING TO HEALTH BENEFIT COVERAGE.—

"(1) BENEFIT REQUIREMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), State laws are superseded, and shall not apply to health benefits coverage made available through an IHP, insofar as such laws impose benefit requirements for such coverage, including requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits.

"(B) EXCEPTION FOR FEDERALLY IMPOSED REQUIREMENTS AND FOR REQUIREMENTS PROHIBITING DISEASE-SPECIFIC EXCLUSIONS.—Subparagraph (A) shall not apply to a requirement to the extent the requirement—

"(i) implements title XXVII or other Federal law; or

''(ii) prohibits imposition of an exclusion of a specific disease from health benefits coverage.

''(2) OTHER REQUIREMENTS PREVENTING OFFERING OF COVERAGE THROUGH AN IHP.—State laws are superseded, and shall not apply to health benefits coverage made available through an IHP, insofar as such laws impose any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through an IHP, if the IHP meets the requirements of this title.

''(c) PREEMPTION OF STATE PREMIUM RATING REQUIREMENTS.—State laws are superseded, and shall not apply to the premiums imposed for health benefits coverage made available through an IHP, insofar as such laws impose restrictions on the variation of premiums among such coverage offered to members of the IHP.

''SEC. 3403. DEFINITIONS.

''For purposes of this title:

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

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

''(2) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term 'health insurance coverage' in section 2791(b)(1), and does not include excepted benefits (as defined in section 2791(c)).

''(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2).

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

''(5) MEMBER.—The term 'member' means, with respect to an IHP, an individual or small employer who is a member of the legal entity described in section 3401(a)(1) to which the IHP is offering coverage.

''(6) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term in section 712(c)(1)(B) of the Employee Retirement Income Security Act of 1974.''.

SEC. 302. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insur-

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

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

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

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

based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

"(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

"(B) to pay other obligations in the normal course of business.

"(7) COVERED LAWS.—

"(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

"(i) individual health insurance coverage issued by a health insurance issuer;

"(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

"(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

"(iv) the provision to an individual in relation to individual health insurance cov-

erage of management, operations, and investment activities of a health insurance issuer; and

''(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

''(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

''(8) STATE.—The term 'State' means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

"(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

"(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

"(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

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

"(E) Refusing to pay claims without conducting a reasonable investigation.

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

"(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

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

''(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

''(J) Failing to provide forms necessary to present claims within 15 calendar days of requests with reasonable explanations regarding their use.

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

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

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

will be presented to or by an insurer, a reinsurer, or broker or its agent, false information as part of, in support of, or concerning a fact material to one or more of the following:

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

''(ii) The rating of an insurance policy or reinsurance contract.

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or 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

and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

''(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

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

''(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

"(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

"(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

"(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

"(D) to comply with a lawful order issued—

"(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

"(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

''(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

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

an insurance agent or broker residing in that secondary State; or

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

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of the primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

'' 'NOTICE

'' 'This policy is issued by _____ and is governed by the laws and regulations of the _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the _____, including coverage of some services or benefits mandated by the law of the _____. Additionally, this policy is not subject to all of the consumer protection laws or re-

strictions on rate changes of the _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

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

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

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

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

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

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

''(B) from raising premium rates for all policy holders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

''(iii) are not obtainable by all individuals to whom coverage is offered;

''(D) from reinstating lapsed coverage; or

''(E) from retroactively adjusting the rates charged an insured individual if the initial rates

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

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

''(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

"(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) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

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

''(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

''(j) STATE POWERS TO ENFORCE STATE LAWS.—

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

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

(h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

''(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements 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 paragraph (1) 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).

''(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in one or more States to deliver health care services; and

''(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

"(I) a non-affiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

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

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

"(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

"(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate

scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

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

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

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

''(B) not be contingent on the decision rendered by the reviewer.

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

respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

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

"(B) The enrollee (or authorized representative).

"(C) The health care professional that provides the items or services involved in the denial.

"(D) The institution at which the items or services (or treatment) involved in the denial are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

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

"(8) DEFINITIONS.—For purposes of this subsection—

"(A) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

"SEC. 2799. ENFORCEMENT.

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

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

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

''(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the

secondary State may notify the applicable State authority of the primary State.''.

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

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and underinsured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

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

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

TITLE IV—ASSOCIATION HEALTH PLANS

SEC. 401. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

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

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

tion, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

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

shall be deemed to be a sponsor described in this subsection.

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

"(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

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

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

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

''(1) a plan which offered such coverage on the date of the enactment of the Obamacare Replacement Act;

''(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating

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

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

"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.

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

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

"(ii) LIMITATION.—

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

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

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

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

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

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', 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 Obamacare Replacement Act, 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 contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

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

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

''(3) the applicable requirements of sections 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 relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

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

"(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) 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 em-

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

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion

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

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

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

''(1) the benefits under the plan consist solely of health insurance coverage; or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

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

''(i) a reserve sufficient for unearned contributions;

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

''(iii) a reserve sufficient for any other obligations of the plan; and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

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

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

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

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

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

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

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

''(1) $500,000; or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, considering the level of aggregate and specific excess/stop loss insurance provided with respect to such plan and other factors related to solvency risk, such as the plan's projected levels of participation or claims, the nature of the plan's liabilities, and the types of assets available to assure that such liabilities are met.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves, excess/stop loss insurance, and indemnification insurance as the applicable authority

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

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under

applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

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

"(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

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

"(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

"(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the

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

''(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) 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 aggregate claims under the plan in excess of an amount or amounts specified in such contract;

''(B) which is guaranteed renewable; and

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

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

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

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

''(B) which is guaranteed renewable; and

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

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

''(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);

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

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

''(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.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Obamacare Replacement Act, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

''(A) A representative of the National Association of Insurance Commissioners.

''(B) A representative of the American Academy of Actuaries.

''(C) A representative of the State governments, or their interests.

''(D) A representative of existing self-insured arrangements, or their interests.

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

''(F) A representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall

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

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

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

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the

plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified health actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

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

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

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

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

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

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an

annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation such interim reports as it considers appropriate.

''(f) ENGAGEMENT OF QUALIFIED HEALTH ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified health actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified health actuary under this part. The qualified health actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

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

The opinion by the qualified health actuary shall be made with 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 health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified health actuary engaged by the plan, and such actuary shall, not later than the end of the following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable au-

thority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

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

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

"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and

other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

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

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

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

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

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee

organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

''(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

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

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan partici-

pants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

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

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

''(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

"SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Obamacare Replacement Act.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

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

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

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

''(3) such tax is otherwise nondiscriminatory; and

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

"SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

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

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary, except that, in connection with any exercise of the Secretary's authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

"(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"(B) TREATMENT OF VERY SMALL GROUPS.—

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

"(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

"(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any indi-

vidual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED HEALTH ACTUARY.—The term 'qualified health actuary' means an individual who is a member of the American Academy of Actuaries with expertise in health care.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

"(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

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

"(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

"(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

"(b) RULES OF CONSTRUCTION.—

"(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying

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

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

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

"(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an

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

''(3) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to a group health plan in relation to its provision of excepted benefits, as defined in section 733(c).''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and

inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

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

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

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

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not

such other employers are participating employers in such plan.

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

''(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

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

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

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

''(5) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 812, respectively.''.

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

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

(B) in clause (ii)—

(i) by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,''; and

(ii) by striking ''title.'' and inserting ''title, and''; and

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

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

provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

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

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Obamacare Replacement Act shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

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

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

at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

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

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

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating 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.

SEC. 402. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after ''control group,'' the following: ''except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,'';

(2) in clause (iii), by striking ''(iii) the determination'' and inserting the following:

''(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business

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

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

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

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

''(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of

all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 403. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended by adding at the end the following new subsection:

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

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

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are

reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

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

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

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

''(n) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

''(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

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

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

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

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' before ''In accordance''; and

(2) by adding at the end the following new subsection:

''(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

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

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

''(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained; and

''(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 405. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within 1 year after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the ar-

rangement under part 8 of subtitle B of title I of such Act—

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

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

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

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

(E) the arrangement may be certified by any applicable authority with respect to its op-

erations in any State only if it operates in such State on the date of certification.

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

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in subsection (a)(8) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE V—MEDICAID REFORM

SEC. 501. INCREASING STATE FLEXIBILITY TO CONDUCT MEDICAID WAIVERS.

Section 1115(a)(1) of the Social Security Act (42 U.S.C. 1315(a)(1)) is amended—

(1) by striking ''1602, or 1902'' and inserting ''or 1602''; and

(2) by inserting ''and shall waive compliance with section 1902,'' after ''as the case may be,''.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. QUALITY HEALTH CARE COALITION.

(a) APPLICATION OF THE FEDERAL ANTITRUST LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING WITH HEALTH PLANS.—

(1) IN GENERAL.—Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be exempt from the Federal antitrust laws.

(2) LIMITATION.—

(A) NO NEW RIGHT FOR COLLECTIVE CESSATION OF SERVICE.—The exemption provided in paragraph (1) shall not confer any new right to participate in any collective cessation of service to patients not already permitted by existing law.

(B) NO CHANGE IN NATIONAL LABOR RELATIONS ACT.—This section applies only to health care professionals excluded from the National Labor Relations Act (29 U.S.C. 151 et seq.). Nothing in this section shall be construed

as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.

(3) NO APPLICATION TO FEDERAL PROGRAMS.—Nothing in this section shall apply to negotiations between health care professionals and health plans pertaining to benefits provided under any of the following:

(A) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) The Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(C) The State Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(D) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(E) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

(F) Chapter 89 of title 5, United States Code (relating to the Federal Employees Health Benefits program).

(G) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) DEFINITIONS.—In this section, the following definitions shall apply:

(1) ANTITRUST LAWS.—The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) GROUP HEALTH PLAN.—The term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(3) GROUP HEALTH PLAN, HEALTH INSURANCE ISSUER.—The terms ''group health plan'' and ''health insurance issuer'' include a third-party administrator or other person acting for or on behalf of such plan or issuer.

(4) HEALTH CARE SERVICES.—The term ''health care services'' means any services for which payment may be made under a health plan, including services related to the delivery or administration of such services.

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual or entity that provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

(6) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or cer-

tificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(7) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a State and that is subject to State law regulating insurance. Such term does not include a group health plan.

(8) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a)));

(B) an organization recognized under State law as a health maintenance organization; or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(9) HEALTH PLAN.—The term ''health plan'' means a group health plan or a health insurance issuer that is offering health insurance coverage.

(10) MEDICAL CARE.—The term ''medical care'' means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; and

(B) transportation primarily for and essential to receiving items and services referred to in subparagraph (A).

(11) PERSON.—The term ''person'' includes a State or unit of local government.

(12) STATE.—The term ''State'' includes the several States, the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(c) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this Act and shall not apply with respect to conduct occurring before such date.

SEC. 602. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

(a) PHSA.—Section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(1)) is amended by adding at the end the following new sentence: ''Such term shall not include a stop loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop loss policy obtained by such plan or sponsor.''.

(b) ERISA.—Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following new sentence: ''Such term shall not include a stop loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants

in excess of a predetermined level set forth in the stop loss policy obtained by such plan or sponsor.''.

(c) IRC.—Section 9832(b)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''Such term shall not include a stop loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop loss policy obtained by such plan or sponsor.''.

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