

114TH CONGRESS  
2D SESSION

# S. 2519

To provide for incentives to encourage health insurance coverage, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

FEBRUARY 9, 2016

Mr. MCCAIN (for himself and Mr. PERDUE) introduced the following bill;  
which was read twice and referred to the Committee on Finance

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## A BILL

To provide for incentives to encourage health insurance coverage, and for other purposes.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Empowering Patients First Act of 2015”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Repeal of PPACA and health care-related HCERA provisions.
- Sec. 3. No mandate of guaranteed issue or community rating.

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH  
INSURANCE COVERAGE

Subtitle A—Tax Credit for Health Insurance Coverage

- Sec. 101. Refundable tax credit for health insurance coverage.
- Sec. 102. Election of tax credit instead of alternative government or group plan benefits.

Subtitle B—Health Savings Accounts

- Sec. 111. Refundable tax credit for health savings account contributions.
- Sec. 112. Allowing HSA rollover to child or parent of account holder.
- Sec. 113. Maximum contribution limit to HSA coordinated with retirement savings account limitation.
- Sec. 114. Transfer of required minimum distribution from retirement plan to health savings account.
- Sec. 115. Equivalent bankruptcy protections for health savings accounts as retirement funds.
- Sec. 116. Allow both spouses to make catch-up contributions to the same HSA account.
- Sec. 117. Provisions relating to Medicare.
- Sec. 118. Individuals eligible for veterans benefits for a service-connected disability.
- Sec. 119. Individuals eligible for Indian Health Service assistance.
- Sec. 120. Individuals eligible for TRICARE coverage.
- Sec. 121. FSA and HRA interaction with HSAs.
- Sec. 122. Special rule for certain medical expenses incurred before establishment of account.
- Sec. 123. Preventive care prescription drug clarification.
- Sec. 124. Administrative error correction before due date of return.
- Sec. 125. Members of health care sharing ministries eligible to establish health savings accounts.
- Sec. 126. High deductible health plans renamed HSA qualified plans.
- Sec. 127. Treatment of direct primary care service arrangements.
- Sec. 128. Certain provider fees to be treated as medical care.
- Sec. 129. Clarification of treatment of capitated primary care payments as amounts paid for medical care.

Subtitle C—Other Provisions

- Sec. 131. Limitation on employer-provided health care coverage.
- Sec. 132. Limitation on abortion funding.
- Sec. 133. No government discrimination against certain health care entities.
- Sec. 134. Equal employer contribution rule to promote choice.
- Sec. 135. Limitations on State restrictions on employer auto-enrollment.
- Sec. 136. Credit for small employers adopting auto-enrollment and defined contribution options.

TITLE II—HEALTH CARE ACCESS AND AVAILABILITY

Subtitle A—Health Insurance Pooling Mechanisms for Individuals

- Sec. 201. Federal grants for State insurance expenditures.
- Sec. 202. Pool reform for individual membership expansion.

Subtitle B—Small Business Health Fairness

- Sec. 211. Short title.
- Sec. 212. Rules governing association health plans.

- Sec. 213. Clarification of treatment of single employer arrangements.
- Sec. 214. Enforcement provisions relating to association health plans.
- Sec. 215. Cooperation between Federal and State authorities.
- Sec. 216. Effective date and transitional and other rules.

#### Subtitle C—Health Insurance Reforms

- Sec. 221. Requirements for individual health insurance.

#### TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

- Sec. 301. Cooperative governing of individual health insurance coverage.

#### TITLE IV—LAWSUIT ABUSE REFORMS

- Sec. 401. Change in burden of proof based on compliance with clinical practice guidelines.
- Sec. 402. State grants to create expert panels and administrative health care tribunals.
- Sec. 403. Payment of damages and recovery of costs in health care lawsuits.
- Sec. 404. Definitions.
- Sec. 405. Effect on other laws.
- Sec. 406. Applicability; effective date.

#### TITLE V—WELLNESS AND PREVENTION

- Sec. 501. Providing financial incentives for treatment compliance.

#### TITLE VI—TRANSPARENCY AND INSURANCE REFORM MEASURES

- Sec. 601. Receipt and response to requests for claim information.

#### TITLE VII—QUALITY

- Sec. 701. Prohibition on certain uses of data obtained from comparative effectiveness research or from patient-centered outcomes research; accounting for personalized medicine and differences in patient treatment response.
- Sec. 702. Establishment of performance-based quality measures.

#### TITLE VIII—STATE TRANSPARENCY PLAN PORTAL

- Sec. 801. Providing information on health coverage options and health care providers.

#### TITLE IX—PATIENT FREEDOM OF CHOICE

- Sec. 901. Guaranteeing freedom of choice and contracting for patients under Medicare.
- Sec. 902. Preemption of State laws limiting charges for eligible professional services.
- Sec. 903. Health care provider licensure cannot be conditioned on participation in a health plan.
- Sec. 904. Bad debt deduction for doctors to partially offset the cost of providing uncompensated care required to be provided under amendments made by the Emergency Medical Treatment and Labor Act.
- Sec. 905. Right of contract with health care providers.

## TITLE X—QUALITY HEALTH CARE COALITION

Sec. 1001. Quality Health Care Coalition.

1 **SEC. 2. REPEAL OF PPACA AND HEALTH CARE-RELATED**  
2 **HCERA PROVISIONS.**

3 (a) PPACA.—Effective as of the enactment of the  
4 Patient Protection and Affordable Care Act (Public Law  
5 111–148), such Act is repealed, and the provisions of law  
6 amended or repealed by such Act are restored or revived  
7 as if such Act had not been enacted.

8 (b) HEALTH CARE-RELATED PROVISIONS IN THE  
9 HEALTH CARE AND EDUCATION RECONCILIATION ACT OF  
10 2010.—Effective as of the enactment of the Health Care  
11 and Education Reconciliation Act of 2010 (Public Law  
12 111–152), title I and subtitle B of title II of such Act  
13 are repealed, and the provisions of law amended or re-  
14 pealed by such title or subtitle, respectively, are restored  
15 or revived as if such title and subtitle had not been en-  
16 acted.

17 **SEC. 3. NO MANDATE OF GUARANTEED ISSUE OR COMMU-**  
18 **NITY RATING.**

19 Nothing in this Act shall be construed to provide a  
20 mandate for guaranteed issue or community rating in the  
21 private insurance market.

1 **TITLE I—TAX INCENTIVES FOR**  
2 **MAINTAINING HEALTH IN-**  
3 **SURANCE COVERAGE**

4 **Subtitle A—Tax Credit for Health**  
5 **Insurance Coverage**

6 **SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSUR-**  
7 **ANCE COVERAGE.**

8 (a) IN GENERAL.—Subpart C of part IV of sub-  
9 chapter A of chapter 1 of the Internal Revenue Code of  
10 1986, as amended by section 2, is amended by inserting  
11 after section 36A the following new section:

12 **“SEC. 36B. HEALTH INSURANCE COVERAGE.**

13 “(a) IN GENERAL.—In the case of an individual,  
14 there shall be allowed as a credit against the tax imposed  
15 by subtitle A an amount equal to the aggregate monthly  
16 credit amounts determined under subsection (b) with re-  
17 spect to the taxpayer and the taxpayer’s qualifying family  
18 members for eligible coverage months beginning during  
19 the taxable year.

20 “(b) MONTHLY CREDIT AMOUNTS.—

21 “(1) IN GENERAL.—The monthly credit amount  
22 with respect to any individual for any eligible cov-  
23 erage month is  $\frac{1}{12}$  of—

1           “(A) \$900 in the case of an individual who  
2           has not attained age 18 as of the beginning of  
3           such month,

4           “(B) \$1,200 in the case of an individual  
5           who has so attained age 18 but who has not so  
6           attained age 35,

7           “(C) \$2,100 in the case of an individual  
8           who has so attained age 35, but who has not  
9           so attained age 50, and

10           “(D) \$3,000 in the case of an individual  
11           who has so attained age 50.

12           “(2) INFLATION ADJUSTMENT.—In the case of  
13           any taxable year beginning in a calendar year after  
14           2016, each of the dollar amounts in paragraph (1)  
15           shall be increased by an amount equal to—

16           “(A) such dollar amount, multiplied by

17           “(B) the cost-of-living adjustment deter-  
18           mined under section 1(f)(3) for the calendar  
19           year in which the taxable year begins, deter-  
20           mined by substituting ‘calendar year 2015’ for  
21           ‘calendar year 1992’ in subparagraph (B)  
22           thereof.

23           Any increase determined under the preceding sen-  
24           tence shall be rounded to the nearest multiple of  
25           \$50.

1       “(c) ELIGIBLE COVERAGE MONTH.—For purposes of  
2 this section, the term ‘eligible coverage month’ means,  
3 with respect to any individual, any month if, as of the first  
4 day of such month, the individual—

5               “(1) is covered by qualified health insurance,  
6               “(2) does not have other specified coverage, and  
7               “(3) is not imprisoned under Federal, State, or  
8 local authority.

9       “(d) QUALIFYING FAMILY MEMBER.—For purposes  
10 of this section, the term ‘qualifying family member’  
11 means—

12               “(1) in the case of a joint return, the taxpayer’s  
13 spouse, and

14               “(2) any dependent of the taxpayer.

15       “(e) QUALIFIED HEALTH INSURANCE.—For pur-  
16 poses of this section, the term ‘qualified health insurance’  
17 means health insurance coverage (other than excepted  
18 benefits as defined in section 9832(c)) which constitutes  
19 medical care.

20       “(f) OTHER SPECIFIED COVERAGE.—For purposes of  
21 this section, an individual has other specified coverage for  
22 any month if, as of the first day of such month—

23               “(1) COVERAGE UNDER MEDICARE, MEDICAID,  
24 OR SCHIP.—Such individual—

1           “(A) is entitled to benefits under part A of  
2 title XVIII of the Social Security Act or is en-  
3 rolled under part B of such title, or

4           “(B) is enrolled in the program under title  
5 XIX or XXI of such Act (other than under sec-  
6 tion 1928 of such Act).

7           “(2) CERTAIN OTHER COVERAGE.—Such indi-  
8 vidual—

9           “(A) is enrolled in a health benefits plan  
10 under chapter 89 of title 5, United States Code,

11           “(B) is entitled to receive benefits under  
12 chapter 55 of title 10, United States Code,

13           “(C) is entitled to receive benefits under  
14 chapter 17 of title 38, United States Code,

15           “(D) is enrolled in a group health plan  
16 (within the meaning of section 5000(b)(1))  
17 which is subsidized by the employer, or

18           “(E) is a member of a health care sharing  
19 ministry.

20           “(3) HEALTH CARE SHARING MINISTRY.—For  
21 purposes of this subsection, the term ‘health care  
22 sharing ministry’ means an organization—

23           “(A) which is described in section  
24 501(c)(3) and is exempt from taxation under  
25 section 501(a),



1           “(B) members of which share a common  
2 set of ethical or religious beliefs and share med-  
3 ical expenses among members in accordance  
4 with those beliefs and without regard to the  
5 State in which a member resides or is em-  
6 ployed,

7           “(C) members of which retain membership  
8 even after they develop a medical condition,

9           “(D) which (or a predecessor of which) has  
10 been in existence at all times since December  
11 31, 1999, and medical expenses of the members  
12 of which have been shared continuously and  
13 without interruption since at least December  
14 31, 1999, and

15           “(E) which conducts an annual audit  
16 which is performed by an independent certified  
17 public accounting firm in accordance with gen-  
18 erally accepted accounting principles and which  
19 is made available to the public upon request.

20           “(g) SPECIAL RULES.—

21           “(1) CREDIT IN EXCESS OF PREMIUMS ONLY  
22 PAYABLE TO A HEALTH SAVINGS ACCOUNT.—

23           “(A) IN GENERAL.—If the credit deter-  
24 mined under subsection (a) (determined without  
25 regard to clause (ii)) for any taxable year ex-

1 ceeds the amount of premiums paid by the tax-  
2 payer for coverage of the taxpayer and the tax-  
3 payer's qualifying family members under quali-  
4 fied health insurance for eligible coverage  
5 months beginning in the taxable year—

6 “(i) at the request of the taxpayer,  
7 the Secretary shall pay the amount of such  
8 excess to one or more health savings ac-  
9 counts of the taxpayer or of any qualifying  
10 family member of the taxpayer, and

11 “(ii) the amount of such excess shall  
12 not be treated as a credit against the tax  
13 imposed by subtitle A for such taxable  
14 year.

15 “(B) MEDICAL AND HEALTH SAVINGS AC-  
16 COUNTS.—Amounts distributed from an Archer  
17 MSA (as defined in section 220(d)) or from a  
18 health savings account (as defined in section  
19 223(d)) shall not be taken into account under  
20 subparagraph (A) as premiums paid for cov-  
21 erage.

22 “(C) INSURANCE WHICH COVERS OTHER  
23 INDIVIDUALS.—For purposes of this paragraph,  
24 rules similar to the rules of section 213(d)(6)  
25 shall apply with respect to any contract for

1 qualified health insurance under which amounts  
2 are payable for coverage of an individual other  
3 than the taxpayer and qualifying family mem-  
4 bers.

5 “(D) CONTRIBUTIONS TREATED AS ROLL-  
6 OVERS, ETC.—

7 “(i) IN GENERAL.—Any amount paid  
8 by the Secretary to a health savings ac-  
9 count under this paragraph shall be treat-  
10 ed for purposes of this title in the same  
11 manner as a rollover contribution to such  
12 an account described in section 223(f)(5),  
13 except that the limitation under section  
14 223(f)(5)(B) shall not apply to such a con-  
15 tribution and such contribution shall not  
16 be taken into account in applying such lim-  
17 itation to any other amounts contributed.

18 “(ii) COORDINATION WITH HSAS.—  
19 Nothing in any provision of law shall be  
20 construed—

21 “(I) to prevent an individual  
22 from establishing a health savings ac-  
23 count (as defined in section 223(d))  
24 merely because such individual is not

1 an eligible individual (as defined in  
2 section 223(c)), or

3 “(II) to prevent such an account  
4 from being treated as a health savings  
5 account merely because all or a sub-  
6 stantial portion of the contributions to  
7 such account are described in this  
8 paragraph.

9 “(2) COORDINATION WITH ADVANCE PAYMENTS  
10 OF CREDIT.—With respect to any taxable year—

11 “(A) the amount which would (but for this  
12 subsection) be allowed as a credit to the tax-  
13 payer under subsection (a) shall be reduced  
14 (but not below zero) by the aggregate amount  
15 paid on behalf of such taxpayer under section  
16 7529 for months beginning in such taxable  
17 year, and

18 “(B) the tax imposed by section 1 for such  
19 taxable year shall be increased by the excess (if  
20 any) of—

21 “(i) the aggregate amount paid on be-  
22 half of such taxpayer under section 7529  
23 for months beginning in such taxable year,  
24 over

1                   “(ii) the amount which would (but for  
2                   this subsection) be allowed as a credit to  
3                   the taxpayer under subsection (a).

4                   “(3) COORDINATION WITH OTHER PROVI-  
5                   SIONS.—For purposes of any deduction allowed  
6                   under section 162(l), 213, or 224, and any credit al-  
7                   lowed under section 35, any health insurance pre-  
8                   miums which would (but for this paragraph) be  
9                   taken into account shall be reduced (but not below  
10                  zero) by the amount of the credit allowed under this  
11                  section (determined without regard to paragraphs  
12                  (1) and (2)).

13                  “(4) DENIAL OF CREDIT TO DEPENDENTS AND  
14                  NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—  
15                  No credit shall be allowed under this section to any  
16                  individual who is—

17                         “(A) not a citizen or lawful permanent  
18                         resident of the United States for the calendar  
19                         year in which the taxable year begins, or

20                         “(B) a dependent with respect to another  
21                         taxpayer for a taxable year beginning in the  
22                         calendar year in which such individual’s taxable  
23                         year begins.

24                  “(5) REGULATIONS.—The Secretary may pre-  
25                  scribe such regulations and other guidance as may

1 be necessary or appropriate to carry out this section,  
2 section 6050W, and section 7529.”.

3 (b) **ADVANCE PAYMENT OF CREDIT.**—

4 (1) **IN GENERAL.**—Chapter 77 of the Internal  
5 Revenue Code of 1986 is amended by adding at the  
6 end the following:

7 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH**  
8 **INSURANCE COVERAGE.**

9 “(a) **GENERAL RULE.**—Not later than January 1,  
10 2016, the Secretary shall establish a program for making  
11 payments to—

12 “(1) providers of qualified health insurance (as  
13 defined in section 36B(e)), and

14 “(2) as provided in subsection (c), health sav-  
15 ings accounts,

16 on behalf of taxpayers eligible for the credit under section  
17 36B.

18 “(b) **AMOUNT OF PAYMENTS.**—The aggregate pay-  
19 ments made under this section with respect to any tax-  
20 payer, determined as of any time during any calendar  
21 year, shall not exceed the monthly credit amounts deter-  
22 mined with respect to such taxpayer under section 36B  
23 for months during such calendar year which have ended  
24 as of such time.

1       “(c) APPLICATION OF RULE THAT CREDITS IN EX-  
2 CESS OF PREMIUMS ONLY PAYABLE TO A HEALTH SAV-  
3 INGS ACCOUNT.—Under rules similar to the rules of sec-  
4 tion 36B(g)(1), any amount otherwise payable on behalf  
5 of the taxpayer under subsection (b) with respect to any  
6 eligible coverage month which is in excess of the amount  
7 of premiums paid by the taxpayer for coverage of the tax-  
8 payer and the taxpayer’s qualifying family members under  
9 qualified health insurance for such month shall be payable  
10 only to one or more health savings accounts of the tax-  
11 payer or of any qualifying family member of the taxpayer.

12       “(d) CERTIFICATION PROCESS AND PROOF OF COV-  
13 ERAGE.—The Secretary shall establish a process under  
14 which individuals are certified as eligible for payment  
15 under this section. Such process shall include an initial  
16 application by the taxpayer to determine eligibility and  
17 thereafter continued eligibility shall be determined, to the  
18 maximum extent feasible, by the Secretary on the basis  
19 of information provided under section 6050X.

20       “(e) DEFINITIONS.—For purposes of this section,  
21 terms used in this section which are also used in section  
22 36B shall have the same meaning as when used in section  
23 36B.”.

24               (2) INFORMATION REPORTING.—

1 (A) IN GENERAL.—Subpart B of part III  
2 of subchapter A of chapter 61 of such Code is  
3 amended by adding at the end the following  
4 new section:

5 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH**  
6 **INSURANCE COVERAGE.**

7 “(a) REQUIREMENT OF REPORTING.—Every person  
8 who provides qualified health insurance for any month of  
9 any calendar year with respect to any individual shall, at  
10 such time as the Secretary may prescribe, make the return  
11 described in subsection (b) with respect to each such indi-  
12 vidual. With respect to any individual with respect to  
13 whom payments under section 7529 are made by the Sec-  
14 retary, the Secretary may require that reporting under  
15 subsection (b) be made on a monthly basis.

16 “(b) FORM AND MANNER OF RETURNS.—A return  
17 is described in this subsection if such return—

18 “(1) is in such form as the Secretary may pre-  
19 scribe, and

20 “(2) contains, with respect to each policy of  
21 qualified health insurance—

22 “(A) the name, address, and TIN of each  
23 individual covered under such policy,

24 “(B) the premiums paid with respect to  
25 such policy, and



1                   “(C) such other information as the Sec-  
2                   retary may prescribe.

3                   “(c) STATEMENTS TO BE FURNISHED TO INDIVID-  
4                   UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
5                   QUIRED.—Every person required to make a return under  
6                   subsection (a) shall furnish to each individual whose name  
7                   is required to be set forth in such return a written state-  
8                   ment showing—

9                   “(1) the name and address of the person re-  
10                  quired to make such return and the phone number  
11                  of the information contact for such person, and

12                  “(2) the information required to be shown on  
13                  the return with respect to such individual.

14                  The written statement required under the preceding sen-  
15                  tence shall be furnished on or before January 31 of the  
16                  year following the calendar year to which such statement  
17                  relates.

18                  “(d) DEFINITIONS.—For purposes of this section,  
19                  terms used in this section which are also used in section  
20                  36B shall have the same meaning as when used in section  
21                  36B.”.

22                                   (B) ASSESSABLE PENALTIES.—

23                                   (i) Subparagraph (B) of section  
24                                   6724(d)(1) of such Code, as amended by  
25                                   section 2, is amended by striking “or” at

1 the end of clause (xxii), by striking “and”  
 2 at the end of clause (xxiii) and inserting  
 3 “or”, and by inserting after clause (xxiii)  
 4 the following new clause:

5 “(xxiv) section 6050X (relating to re-  
 6 turns relating to credit for health insur-  
 7 ance coverage), and”.

8 (ii) Paragraph (2) of section 6724(d)  
 9 of such Code, as amended by section 2, is  
 10 amended by striking “or” at the end of  
 11 subparagraph (EE), by striking the period  
 12 at the end of subparagraph (FF) and in-  
 13 sserting “, or”, and by adding after sub-  
 14 paragraph (FF) the following new sub-  
 15 paragraph:

16 “(GG) section 6050X (relating to returns  
 17 relating to credit for health insurance cov-  
 18 erage).”.

19 (3) DISCLOSURE OF RETURN INFORMATION  
 20 FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT  
 21 AS PREMIUMS FOR QUALIFIED HEALTH INSUR-  
 22 ANCE.—

23 (A) IN GENERAL.—Subsection (l) of sec-  
 24 tion 6103 of such Code, as amended by section

1           2, is amended by adding at the end the fol-  
2           lowing new paragraph:

3           “(21) DISCLOSURE OF RETURN INFORMATION  
4           RELATED TO PAYMENTS OF THE HEALTH INSUR-  
5           ANCE COVERAGE CREDIT.—The Secretary may, on  
6           behalf of taxpayers eligible for the credit under sec-  
7           tion 36B, disclose to a provider of qualified health  
8           insurance (as defined in section 36(e)) or a trustee  
9           of a health savings account (and persons acting on  
10          behalf of such provider or such trustee), return in-  
11          formation with respect to any such taxpayer only to  
12          the extent necessary (as prescribed by regulations  
13          issued by the Secretary) to carry out sections  
14          36B(g)(1) (relating to credit in excess of premiums  
15          only payable to a health savings account) and 7529  
16          (relating to advance payment of credit for health in-  
17          surance coverage).”.

18                   (B) CONFIDENTIALITY OF INFORMA-  
19                   TION.—Paragraph (3) of section 6103(a) of  
20                   such Code, as amended by section 2, is amend-  
21                   ed by striking “or (20)” and inserting “(20), or  
22                   (21)”.

23                   (C) UNAUTHORIZED DISCLOSURE.—Para-  
24                   graph (2) of section 7213(a) of such Code, as

1           amended by section 2, is amended by striking  
2           “or (20)” and inserting “(20), or (21)”.

3           (4) EFFECTIVE DATE.—The amendments made  
4           by this section shall take effect on the date of the  
5           enactment of this Act.

6           (c) CONFORMING AMENDMENTS.—

7           (1) Paragraph (2) of section 1324(b) of title  
8           31, United States Code, as amended by section 2, is  
9           amended by inserting “36B,” after “36A,”.

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

“Sec. 36B. Health insurance coverage.”.

15          (3) The table of sections for subpart B of part  
16          III of subchapter A of chapter 61 of such Code is  
17          amended by adding at the end the following new  
18          item:

“Sec. 6050X. Returns relating to credit for health insurance coverage.”.

19          (4) The table of sections for chapter 77 of such  
20          Code is amended by adding at the end the following  
21          new item:

“Sec. 7529. Advance payment of credit for health insurance coverage.”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2015.

4 **SEC. 102. ELECTION OF TAX CREDIT INSTEAD OF ALTER-**  
5 **NATIVE GOVERNMENT OR GROUP PLAN BEN-**  
6 **EFITS.**

7 (a) IN GENERAL.—Notwithstanding any other provi-  
8 sion of law, an individual who is otherwise eligible for ben-  
9 efits under a health program (as defined in subsection (c))  
10 may elect, in a form and manner specified by the Sec-  
11 retary of Health and Human Services in consultation with  
12 the Secretary of the Treasury, to receive a tax credit de-  
13 scribed in section 36B of the Internal Revenue Code of  
14 1986 (which shall be used for the purpose of health insur-  
15 ance coverage) in lieu of receiving any benefits under such  
16 program.

17 (b) EFFECTIVE DATE.—An election under subsection  
18 (a) may first be made for calendar year 2016 and any  
19 such election shall be effective for such period (not less  
20 than one calendar year) as the Secretary of Health and  
21 Human Services shall specify, in consultation with the  
22 Secretary of the Treasury.

23 (c) HEALTH PROGRAM DEFINED.—For purposes of  
24 this section, the term “health program” means any of the  
25 following:

1           (1) **MEDICARE**.—The Medicare program under  
2 part A of title XVIII of the Social Security Act.

3           (2) **MEDICAID**.—The Medicaid program under  
4 title XIX of such Act (including such a program op-  
5 erating under a Statewide waiver under section 1115  
6 of such Act).

7           (3) **SCHIP**.—The State children’s health insur-  
8 ance program under title XXI of such Act.

9           (4) **TRICARE**.—The **TRICARE** program  
10 under chapter 55 of title 10, United States Code.

11           (5) **VETERANS BENEFITS**.—Coverage for bene-  
12 fits under chapter 17 of title 38, United States  
13 Code.

14           (6) **FEHBP**.—Coverage under chapter 89 of  
15 title 5, United States Code.

16           (7) **SUBSIDIZED GROUP HEALTH PLANS**.—Cov-  
17 erage under a group health plan (within the meaning  
18 of section 5000(b)(1)) which is subsidized by the  
19 employer.

20           (d) **OTHER SOCIAL SECURITY BENEFITS NOT**  
21 **WAIVED**.—An election to waive the benefits described in  
22 subsection (c)(1) shall not result in the waiver of any other  
23 benefits under the Social Security Act.

1           **Subtitle B—Health Savings**  
2                           **Accounts**

3   **SEC. 111. REFUNDABLE TAX CREDIT FOR HEALTH SAVINGS**

4                           **ACCOUNT CONTRIBUTIONS.**

5           (a) **IN GENERAL.**—Subpart C of part IV of sub-  
6 chapter A of chapter 1 of the Internal Revenue Code of  
7 1986, as amended by the preceding provisions of this Act,  
8 is amended by inserting after section 36B the following  
9 new section:

10   **“SEC. 36C. HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.**

11           “(a) **IN GENERAL.**—In the case of an individual who  
12 is allowed a deduction under section 223(a) for any tax-  
13 able year, there shall be allowed as a credit against the  
14 tax imposed by subtitle A for such taxable year, the lesser  
15 of—

16                   “(1) the amount so allowed as a deduction, or

17                   “(2) \$1,000.

18           “(b) **LIMITATION.**—The credit allowed under sub-  
19 section (a) with respect to any individual for any taxable  
20 year shall not exceed the excess (if any) of—

21                   “(1) \$1,000, over

22                   “(2) the aggregate credits allowed with respect  
23 to such individual under subsection (a) for all prior  
24 taxable years.”.

25           (b) **CONFORMING AMENDMENTS.**—





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

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

12 **SEC. 113. MAXIMUM CONTRIBUTION LIMIT TO HSA COORDI-**  
13 **NATED WITH RETIREMENT SAVINGS AC-**  
14 **COUNT LIMITATION.**

15           (a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A)  
16 of the Internal Revenue Code of 1986 is amended by strik-  
17 ing “\$2,250” and inserting “the amount in effect under  
18 section 219(b)(5)(A)”.

19           (b) FAMILY COVERAGE.—Section 223(b)(2)(B) of the  
20 Internal Revenue Code of 1986 is amended by striking  
21 “\$4,500” and inserting “twice the amount in effect under  
22 subparagraph (A)”.

23           (c) CONFORMING AMENDMENTS.—Section 223(g)(1)  
24 of the Internal Revenue Code of 1986 is amended—

1 (1) in the matter preceding subparagraph (A),  
 2 by striking “subsections (b)(2) and (c)(2)(A)” and  
 3 inserting “subsection (c)(2)(A)”,

4 (2) in subparagraph (B), by striking “by sub-  
 5 stituting” and all that follows through the end of  
 6 clause (ii) and inserting “by substituting ‘calendar  
 7 year 2003’ for ‘calendar year 1992’ in subparagraph  
 8 (B) thereof.”, and

9 (3) in the matter following subparagraph (B),  
 10 by striking “subsections (b)(2) and (c)(2)(A)” and  
 11 inserting “subsection (c)(2)(A)”.

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

15 **SEC. 114. TRANSFER OF REQUIRED MINIMUM DISTRIBUTION FROM RETIREMENT PLAN TO HEALTH SAVINGS ACCOUNT.**

16 (a) TRANSFER FROM RETIREMENT PLAN.—

17 (1) INDIVIDUAL RETIREMENT ACCOUNTS.—Sec-  
 18 tion 408(d) of the Internal Revenue Code of 1986  
 19 is amended by adding at the end the following new  
 20 paragraph:  
 21

22 “(10) REQUIRED MINIMUM DISTRIBUTION  
 23 TRANSFERRED TO HEALTH SAVINGS ACCOUNT.—  
 24

1           “(A) IN GENERAL.—In the case of an indi-  
2           vidual who has attained the age of 70½ and  
3           who elects the application of this paragraph for  
4           a taxable year, gross income of the individual  
5           for the taxable year does not include a qualified  
6           HSA transfer to the extent such transfer is oth-  
7           erwise includible in gross income.

8           “(B) QUALIFIED HSA TRANSFER.—For  
9           purposes of this paragraph, the term ‘qualified  
10          HSA transfer’ means any distribution from an  
11          individual retirement plan—

12                   “(i) to a health savings account of the  
13                   individual in a direct trustee-to-trustee  
14                   transfer, and

15                   “(ii) to the extent such distribution  
16                   does not exceed the required minimum dis-  
17                   tribution determined under section  
18                   401(a)(9) for the distribution calendar  
19                   year ending during the taxable year.

20          “(C) APPLICATION OF SECTION 72.—Not-  
21          withstanding section 72, in determining the ex-  
22          tent to which an amount is treated as otherwise  
23          includible in gross for purposes of subparagraph  
24          (A), the aggregate amount distributed from an  
25          individual retirement plan shall be treated as

1 includible in gross income to the extent that  
2 such amount does not exceed the aggregate  
3 amount which would have been so includible if  
4 all amounts from all individual retirement plans  
5 were distributed. Proper adjustments shall be  
6 made in applying section 72 to other distribu-  
7 tions in such taxable year and subsequent tax-  
8 able years.

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

13 (2) OTHER RETIREMENT PLANS.—Section 402  
14 of such Code is amended by adding at the end the  
15 following new subsection:

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

18 “(1) IN GENERAL.—In the case of an individual  
19 who has attained the age of 70½ and who elects the  
20 application of this subsection for a taxable year,  
21 gross income of the individual for the taxable year  
22 does not include a qualified HSA transfer to the ex-  
23 tent such transfer is otherwise includible in gross in-  
24 come.

1           “(2) QUALIFIED HSA TRANSFER.—For pur-  
2           poses of this subsection, the term ‘qualified HSA  
3           transfer’ means any distribution from a retirement  
4           plan—

5                   “(A) to a health savings account of the in-  
6                   dividual in a direct trustee-to-trustee transfer,  
7                   and

8                   “(B) to the extent such distribution does  
9                   not exceed the required minimum distribution  
10                  determined under section 401(a)(9) for the dis-  
11                  tribution calendar year ending during the tax-  
12                  able year.

13           “(3) APPLICATION OF SECTION 72.—Notwith-  
14           standing section 72, in determining the extent to  
15           which an amount is treated as otherwise includible  
16           in gross for purposes of paragraph (1), the aggre-  
17           gate amount distributed from an individual retire-  
18           ment plan shall be treated as includible in gross in-  
19           come to the extent that such amount does not exceed  
20           the aggregate amount which would have been so in-  
21           cludible if all amounts from all individual retirement  
22           plans were distributed. Proper adjustments shall be  
23           made in applying section 72 to other distributions in  
24           such taxable year and subsequent taxable years.

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

6           (b) TRANSFER TO HEALTH SAVINGS ACCOUNT.—

7           (1) IN GENERAL.—Section 223(d)(1)(A) of the  
8           Internal Revenue Code of 1986 is amended by strik-  
9           ing “or” at the end of clause (i), by striking the pe-  
10          riod at the end of clause (ii)(II) and inserting “, or”,  
11          and by adding at the end the following new clause:

12                       “(iii) unless it is a qualified HSA  
13                       transfer described in section 408(d)(10) or  
14                       402(m).”.

15          (2) EXCISE TAX INAPPLICABLE TO QUALIFIED  
16          HSA TRANSFER.—Section 4973(g)(1) of such Code  
17          is amended by inserting “or a qualified HSA trans-  
18          fer described in section 408(d)(10) or 402(m)” after  
19          “or 223(f)(5)”.

20          (c) EFFECTIVE DATE.—The amendments made by  
21          this section shall apply to distributions made after the  
22          date of the enactment of this Act.

1 **SEC. 115. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**  
 2 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**  
 3 **MENT FUNDS.**

4 (a) IN GENERAL.—Section 522 of title 11, United  
 5 States Code, is amended by adding at the end the fol-  
 6 lowing:

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

13 (b) EFFECTIVE DATE.—The amendment made by  
 14 this section shall apply to cases commencing under title  
 15 11, United States Code, after the date of enactment of  
 16 this Act.

17 **SEC. 116. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**  
 18 **TRIBUTIONS TO THE SAME HSA ACCOUNT.**

19 (a) IN GENERAL.—Section 223(b)(3) of the Internal  
 20 Revenue Code of 1986 is amended by adding at the end  
 21 the following new subparagraph:

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

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

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

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

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

13 **SEC. 117. PROVISIONS RELATING TO MEDICARE.**

14           (a) INDIVIDUALS OVER AGE 65 ONLY ENROLLED IN  
15 MEDICARE PART A.—Section 223(b)(7) of the Internal  
16 Revenue Code of 1986 is amended by adding at the end  
17 the following: “This paragraph shall not apply to any indi-  
18 vidual during any period for which the individual’s only  
19 entitlement to such benefits is an entitlement to hospital  
20 insurance benefits under part A of title XVIII of such Act  
21 pursuant to an enrollment for such hospital insurance ben-  
22 efits under section 226(a)(1) of such Act.”.

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



1           (1) IN GENERAL.—Section 138(b) of such Code  
2 is amended by striking paragraph (2) and by redesi-  
3 gnating paragraphs (3) and (4) as paragraphs (2)  
4 and (3), respectively.

5           (2) CONFORMING AMENDMENT.—Section  
6 138(c)(4) of such Code is amended by striking “and  
7 paragraph (2)”.

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

11 **SEC. 118. INDIVIDUALS ELIGIBLE FOR VETERANS BENE-**  
12 **FITS FOR A SERVICE-CONNECTED DIS-**  
13 **ABILITY.**

14           (a) IN GENERAL.—Subparagraph (C) of section  
15 223(e)(1) of the Internal Revenue Code of 1986 is amend-  
16 ed to read as follows:

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

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

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

7 **SEC. 119. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH**  
8 **SERVICE ASSISTANCE.**

9 (a) IN GENERAL.—Section 223(c)(1) of the Internal  
10 Revenue Code of 1986, as amended by the preceding pro-  
11 visions of this Act, is amended by adding at the end the  
12 following new subparagraph:

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

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

1 **SEC. 120. INDIVIDUALS ELIGIBLE FOR TRICARE COVERAGE.**

2 (a) IN GENERAL.—Section 223(c)(1) of the Internal  
3 Revenue Code of 1986, as amended by the preceding pro-  
4 visions of this Act, is amended by adding at the end the  
5 following new subparagraph:

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

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

19 **SEC. 121. FSA AND HRA INTERACTION WITH HSAS.**

20 (a) ELIGIBLE INDIVIDUALS INCLUDE FSA AND HRA  
21 PARTICIPANTS.—Section 223(c)(1)(B) of the Internal  
22 Revenue Code of 1986 is amended—

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

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

3                   “(iv) for months during a plan year in  
4 which a qualified HSA distribution (as de-  
5 fined in section 106(e)(2)) is made on be-  
6 half of an individual, coverage under a  
7 health flexible spending arrangement or a  
8 health reimbursement arrangement if,  
9 after the qualified HSA distribution is  
10 made and for the remaining duration of  
11 the plan year, the coverage provided under  
12 the health flexible spending arrangement  
13 or health reimbursement arrangement is  
14 converted to coverage which—

15                   “(I) does not pay or reimburse  
16 any medical expense incurred before  
17 the minimum annual deductible under  
18 paragraph (2)(A)(i) (prorated for the  
19 period occurring after the qualified  
20 HSA distribution is made) is satisfied,

21                   “(II) does not pay or reimburse  
22 any medical expense incurred after  
23 the qualified HSA distribution is  
24 made other than preventive care as  
25 defined in paragraph (2)(C),

1 “(III) pays or reimburses bene-  
2 fits for coverage described in clause  
3 (ii) (but not through insurance or for  
4 long-term care services),

5 “(IV) pays or reimburses benefits  
6 for permitted insurance or coverage  
7 described in clause (ii) (but not for  
8 long-term care services),

9 “(V) pays or reimburses only  
10 those medical expenses incurred after  
11 an individual’s retirement (and no ex-  
12 penses incurred before retirement), or

13 “(VI) is suspended, pursuant to  
14 an election made on or before the date  
15 the individual elects the qualified  
16 HSA distribution or, if later, on the  
17 date of the individual enrolls in a high  
18 deductible health plan, and which does  
19 not pay or reimburse, at any time,  
20 any medical expense incurred during  
21 the suspension period except as de-  
22 fined in the preceding subclauses of  
23 this clause.”.

24 (b) QUALIFIED HSA DISTRIBUTION SHALL NOT AF-  
25 FECT FLEXIBLE SPENDING ARRANGEMENT.—Section

1 106(e)(1) of the Internal Revenue Code of 1986 is amend-  
 2 ed to read as follows:

3 “(1) IN GENERAL.—A plan shall not fail to be  
 4 treated as a health flexible spending arrangement  
 5 under this section, section 105, or section 125, or as  
 6 a health reimbursement arrangement under this sec-  
 7 tion or section 105, merely because such plan pro-  
 8 vides for a qualified HSA distribution.”.

9 (c) FSA BALANCES AT YEAR END SHALL NOT FOR-  
 10 FEIT.—Section 125(d)(2) of the Internal Revenue Code  
 11 of 1986 is amended by adding at the end the following  
 12 new subparagraph:

13 “(E) EXCEPTION FOR QUALIFIED HSA DIS-  
 14 TRIBUTIONS.—Subparagraph (A) shall not  
 15 apply to the extent that there is an amount re-  
 16 maining in a health flexible spending account at  
 17 the end of a plan year that an individual elects  
 18 to contribute to a health savings account pursu-  
 19 ant to a qualified HSA distribution (as defined  
 20 in section 106(e)(2)).”.

21 (d) SIMPLIFICATION OF LIMITATIONS ON FSA AND  
 22 HRA ROLLOVERS.—Section 106(e)(2) of such Code is  
 23 amended to read as follows:

24 “(2) QUALIFIED HSA DISTRIBUTION.—

1           “(A) IN GENERAL.—The term ‘qualified  
2 HSA distribution’ means a distribution from a  
3 health flexible spending arrangement or health  
4 reimbursement arrangement to the extent that  
5 such distribution does not exceed the lesser  
6 of—

7                   “(i) the balance in such arrangement  
8 as of the date of such distribution, or

9                   “(ii) the amount determined under  
10 subparagraph (B).

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

13           “(B) DOLLAR LIMITATIONS.—

14                   “(i) DISTRIBUTIONS FROM A HEALTH  
15 FLEXIBLE SPENDING ARRANGEMENT.—A  
16 qualified HSA distribution from a health  
17 flexible spending arrangement shall not ex-  
18 ceed the applicable amount.

19                   “(ii) DISTRIBUTIONS FROM A HEALTH  
20 REIMBURSEMENT ARRANGEMENT.—A  
21 qualified HSA distribution from a health  
22 reimbursement arrangement shall not ex-  
23 ceed—

24                           “(I) the applicable amount di-  
25 vided by 12, multiplied by

1                   “(II) the number of months dur-  
2                   ing which the individual is a partici-  
3                   pant in the health reimbursement ar-  
4                   rangement.

5                   “(iii) APPLICABLE AMOUNT.—For  
6                   purposes of this subparagraph, the applica-  
7                   ble amount is—

8                   “(I) the dollar amount in effect  
9                   under section 223(b)(2)(A) in the case  
10                  of an eligible individual who has self-  
11                  only coverage under a high deductible  
12                  health plan at the time of such dis-  
13                  tribution, and

14                  “(II) twice the dollar amount in  
15                  effect under subclause (I) in the case  
16                  of an eligible individual who has fam-  
17                  ily coverage under a high deductible  
18                  health plan at the time of such dis-  
19                  tribution.”.

20                  (e) ELIMINATION OF ADDITIONAL TAX FOR FAILURE  
21 TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COV-  
22 ERAGE.—Section 106(e) of the Internal Revenue Code of  
23 1986 is amended—



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

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

8           (f) LIMITED PURPOSE FSAS AND HRAS.—Section  
9 106(e) of the Internal Revenue Code of 1986, as amended  
10 by this section, is amended by adding at the end the fol-  
11 lowing new paragraph:

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

1 individuals who do not enroll in a high deductible  
2 health plan.”.

3 (g) DISCLAIMER OF DISQUALIFYING COVERAGE.—  
4 Section 223(c)(1)(B) of the Internal Revenue Code of  
5 1986, as amended by this section, is amended—

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

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

9 (3) by inserting after clause (iv) the following  
10 new clause:

11 “(v) coverage (including prospective  
12 coverage) under a health plan that is not  
13 a high deductible health plan which is dis-  
14 claimed in writing, at the time of the cre-  
15 ation or organization of the health savings  
16 account, including by execution of a trust  
17 described in subsection (d)(1) through a  
18 governing instrument that includes such a  
19 disclaimer, or by acceptance of an amend-  
20 ment to such a trust that includes such a  
21 disclaimer.”.

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

1 **SEC. 122. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**  
2 **INCURRED BEFORE ESTABLISHMENT OF AC-**  
3 **COUNT.**

4 (a) IN GENERAL.—Section 223(d)(2) of the Internal  
5 Revenue Code of 1986 is amended by adding at the end  
6 the following new subparagraph:

7 “(D) CERTAIN MEDICAL EXPENSES IN-  
8 CURRED BEFORE ESTABLISHMENT OF ACCOUNT  
9 TREATED AS QUALIFIED.—An expense shall not  
10 fail to be treated as a qualified medical expense  
11 solely because such expense was incurred before  
12 the establishment of the health savings account  
13 if such expense was incurred—

14 “(i) during either—

15 “(I) the taxable year in which the  
16 health savings account was estab-  
17 lished, or

18 “(II) the preceding taxable year  
19 in the case of a health savings ac-  
20 count established after the taxable  
21 year in which such expense was in-  
22 curred but before the time prescribed  
23 by law for filing the return for such  
24 taxable year (not including extensions  
25 thereof), and

1           “(ii) for medical care of an individual  
2           during a period that such individual was  
3           covered by a high deductible health plan  
4           and met the requirements of subsection  
5           (c)(1)(A)(ii) (after application of sub-  
6           section (c)(1)(B)).”.

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

10   **SEC. 123. PREVENTIVE CARE PRESCRIPTION DRUG CLARI-**  
11                           **FICATION.**

12           (a) CLARIFY USE OF DRUGS IN PREVENTIVE  
13           CARE.—Section 223(c)(2)(C) of the Internal Revenue  
14           Code of 1986 is amended by adding at the end the fol-  
15           lowing: “For purposes of the preceding sentence, the term  
16           ‘preventative care’ includes prescription and over-the-  
17           counter drugs and medicines which have the primary pur-  
18           pose of preventing the onset of, further deterioration from,  
19           or complications associated with chronic conditions, ill-  
20           nesses, or diseases.”.

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

1 **SEC. 124. ADMINISTRATIVE ERROR CORRECTION BEFORE**  
2 **DUE DATE OF RETURN.**

3 (a) **IN GENERAL.**—Section 223(f)(4) of the Internal  
4 Revenue Code of 1986 is amended by adding at the end  
5 the following new subparagraph:

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

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

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

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

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

1 **SEC. 125. MEMBERS OF HEALTH CARE SHARING MIN-**  
2 **ISTRIES ELIGIBLE TO ESTABLISH HEALTH**  
3 **SAVINGS ACCOUNTS.**

4 (a) IN GENERAL.—Section 223 of the Internal Rev-  
5 enue Code of 1986 is amended by adding at the end the  
6 following new subsection:

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

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

15 **SEC. 126. HIGH DEDUCTIBLE HEALTH PLANS RENAMED**  
16 **HSA QUALIFIED PLANS.**

17 (a) IN GENERAL.—Section 223 of the Internal Rev-  
18 enue Code of 1986, as amended by this Act, is amended  
19 by striking “high deductible health plan” each place it ap-  
20 pears and inserting “HSA qualified health plan”.

21 (b) CONFORMING AMENDMENTS.—

22 (1) Section 106(e) of the Internal Revenue  
23 Code of 1986, as amended by this Act, is amended  
24 by striking “high deductible health plan” each place  
25 it appears and inserting “HSA qualified health  
26 plan”.

1           (2) The heading for section 223(c)(2) of such  
2 Code is amended by striking “HIGH DEDUCTIBLE  
3 HEALTH PLAN” and inserting “HSA QUALIFIED  
4 HEALTH PLAN”.

5           (3) Section 408(d)(9) of such Code is amend-  
6 ed—

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

11           (B) by striking “HIGH DEDUCTIBLE  
12 HEALTH PLAN” in the heading of subparagraph  
13 (D) and inserting “HSA QUALIFIED HEALTH  
14 PLAN”.

15 **SEC. 127. TREATMENT OF DIRECT PRIMARY CARE SERVICE**  
16 **ARRANGEMENTS.**

17           (a) IN GENERAL.—Section 223(c) of the Internal  
18 Revenue Code of 1986 is amended by adding at the end  
19 the following new paragraph:

20           “(6) TREATMENT OF DIRECT PRIMARY CARE  
21 SERVICE ARRANGEMENTS.—An arrangement under  
22 which an individual is provided coverage restricted to  
23 primary care services in exchange for a fixed peri-  
24 odic fee—

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

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

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

8 **SEC. 128. CERTAIN PROVIDER FEES TO BE TREATED AS**  
9 **MEDICAL CARE.**

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

13           “(12) PERIODIC PROVIDER FEES.—The term  
14           ‘medical care’ includes periodic fees paid to a pri-  
15           mary care physician for the right to receive medical  
16           services on an as-needed basis.”.

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

20 **SEC. 129. CLARIFICATION OF TREATMENT OF CAPITATED**  
21 **PRIMARY CARE PAYMENTS AS AMOUNTS**  
22 **PAID FOR MEDICAL CARE.**

23          (a) IN GENERAL.—Section 213(d) of the Internal  
24 Revenue Code of 1986, as amended by the preceding pro-



1 visions of this Act, is amended by adding at the end the  
 2 following new paragraph:

3           “(13) TREATMENT OF CAPITATED PRIMARY  
 4 CARE PAYMENTS.—Capitated primary care payments  
 5 shall be treated as amounts paid for medical care.”.

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

## 9           **Subtitle C—Other Provisions**

### 10   **SEC. 131. LIMITATION ON EMPLOYER-PROVIDED HEALTH** 11           **CARE COVERAGE.**

12           (a) IN GENERAL.—Section 106 of the Internal Rev-  
 13 enue Code of 1986, as amended by the preceding provi-  
 14 sions of this Act, is amended by adding at the end the  
 15 following new subsection:

16           “(f) LIMITATION ON EMPLOYER-PROVIDED HEALTH  
 17 CARE COVERAGE.—

18           “(1) IN GENERAL.—The amount of any exclu-  
 19 sion under subsection (a) for any taxable year with  
 20 respect to—

21           “(A) any employer-provided coverage  
 22 under an accident or health plan which con-  
 23 stitutes medical care, and

24           “(B) any employer contribution to an Ar-  
 25 cher MSA or a health savings account which is

1           treated by subsection (b) or (d) as employer-  
2           provided coverage for medical expenses under  
3           an accident or health plan,  
4           shall not exceed \$8,000 per employee for self-only  
5           coverage and \$20,000 for family coverage.

6           “(2) INFLATION ADJUSTMENT.—In the case of  
7           any taxable year beginning in a calendar year after  
8           2016, each of the dollar amounts in paragraph (1)  
9           shall be increased by an amount equal to—

10                   “(A) such dollar amount, multiplied by  
11                   “(B) the cost-of-living adjustment deter-  
12                   mined under section 1(f)(3) for the calendar  
13                   year in which the taxable year begins, deter-  
14                   mined by substituting ‘calendar year 2015’ for  
15                   ‘calendar year 1992’ in subparagraph (B)  
16                   thereof.

17           Any increase determined under the preceding sen-  
18           tence shall be rounded to the nearest multiple of  
19           \$50.

20           “(3) MEDICAL CARE.—For purposes of para-  
21           graph (1), the term ‘medical care’ has the meaning  
22           given to such term in section 213(d) determined  
23           without regard to—

24                   “(A) paragraph (1)(C) thereof, and

1           “(B) so much of paragraph (1)(D) thereof  
2           as relates to qualified long-term care insur-  
3           ance.”.

4           (b) EFFECTIVE DATE.—The amendment made by  
5 this section shall apply to taxable years beginning after  
6 December 31, 2015.

7 **SEC. 132. LIMITATION ON ABORTION FUNDING.**

8           No funds authorized under, or credits or deductions  
9 allowed under the Internal Revenue Code of 1986 by rea-  
10 son of, this Act (or any amendment made by this Act)  
11 may be used to pay for any abortion or to cover any part  
12 of the costs of any health plan that includes coverage of  
13 abortion, except in the case where a woman suffers from  
14 a physical disorder, physical injury, or physical illness that  
15 would, as certified by a physician, place the woman in dan-  
16 ger of death unless an abortion is performed, including  
17 a life-endangering physical condition caused by or arising  
18 from the pregnancy itself, or unless the pregnancy is the  
19 result of an act of rape or incest.

20 **SEC. 133. NO GOVERNMENT DISCRIMINATION AGAINST**  
21 **CERTAIN HEALTH CARE ENTITIES.**

22           (a) NON-DISCRIMINATION.—A Federal agency or  
23 program, and any State or local government that receives  
24 Federal financial assistance under this Act or any amend-  
25 ment made by this Act (either directly or indirectly), may

1 not subject any individual or institutional health care enti-  
2 ty to discrimination on the basis that the health care enti-  
3 ty does not provide, pay for, provide coverage of, or refer  
4 for abortions.

5 (b) HEALTH CARE ENTITY DEFINED.—For purposes  
6 of this section, the term “health care entity” includes an  
7 individual physician or other health care professional, a  
8 hospital, a provider-sponsored organization, a health  
9 maintenance organization, a health insurance plan, or any  
10 other kind of health care facility, organization, or plan.

11 (c) REMEDIES.—

12 (1) IN GENERAL.—The courts of the United  
13 States shall have jurisdiction to prevent and redress  
14 actual or threatened violations of this section by  
15 issuing any form of legal or equitable relief, includ-  
16 ing—

17 (A) injunctions prohibiting conduct that  
18 violates this section; and

19 (B) orders preventing the disbursement of  
20 all or a portion of Federal financial assistance  
21 to a State or local government, or to a specific  
22 offending agency or program of a State or local  
23 government, until such time as the conduct pro-  
24 hibited by this section has ceased.

1           (2) COMMENCEMENT OF ACTION.—An action  
2 under this subsection may be instituted by—

3           (A) any health care entity that has stand-  
4           ing to complain of an actual or threatened vio-  
5           lation of this section; or

6           (B) the Attorney General of the United  
7           States.

8           (d) ADMINISTRATION.—The Secretary of Health and  
9 Human Services shall designate the Director of the Office  
10 for Civil Rights of the Department of Health and Human  
11 Services—

12           (1) to receive complaints alleging a violation of  
13 this section;

14           (2) subject to paragraph (3), to pursue the in-  
15 vestigation of such complaints in coordination with  
16 the Attorney General; and

17           (3) in the case of a complaint related to a Fed-  
18 eral agency (other than with respect to the Depart-  
19 ment of Health and Human Services) or program  
20 administered through such other agency or any  
21 State or local government receiving Federal financial  
22 assistance through such other agency, to refer the  
23 complaint to the appropriate office of such other  
24 agency.

1 **SEC. 134. EQUAL EMPLOYER CONTRIBUTION RULE TO PRO-**  
2 **MOTE CHOICE.**

3 (a) IN GENERAL.—Section 5000 of the Internal Rev-  
4 enue Code of 1986 is amended by adding at the end the  
5 following new subsection:

6 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

7 “(1) IN GENERAL.—Subsection (a) shall not  
8 apply in the case of a group health plan with respect  
9 to which the requirements of paragraphs (2) and (3)  
10 are met.

11 “(2) CONTRIBUTION ELECTION.—The require-  
12 ment of this paragraph is met with respect to a  
13 group health plan if any employee of an employer  
14 (who but for this paragraph would be covered by  
15 such plan) may elect to have the employer or em-  
16 ployee organization pay an amount which is not less  
17 than the contribution amount to any provider of  
18 health insurance coverage which constitutes medical  
19 care of the individual or individual’s spouse or de-  
20 pendants (other than excepted benefits as defined in  
21 section 9832(c)) in lieu of such group health plan  
22 coverage otherwise provided or contributed to by the  
23 employer with respect to such employee.

24 “(3) PRE-EXISTING CONDITIONS.—

25 “(A) IN GENERAL.—The requirement of  
26 this paragraph is met with respect to health in-

1 insurance coverage provided to a participant or  
2 beneficiary by any health insurance issuer if,  
3 under such plan the requirements of section  
4 9801 are met with respect to the participant or  
5 beneficiary.

6 “(B) ENFORCEMENT WITH RESPECT TO  
7 INDIVIDUAL ELECTION.—For purposes of sub-  
8 paragraph (A), any health insurance coverage  
9 with respect to the participant or beneficiary  
10 shall be treated as health insurance coverage  
11 under a group health plan to which section  
12 9801 applies.

13 “(4) CONTRIBUTION AMOUNT.—For purposes  
14 of this section, the term ‘contribution amount’  
15 means, with respect to an individual under a group  
16 health plan, the portion of the applicable premium of  
17 such individual under such plan (as determined  
18 under section 4980B(f)(4)) which is not paid by the  
19 individual. In the case that the employer offers more  
20 than one group health plan, the contribution amount  
21 shall be the average amount of the applicable pre-  
22 miums under such plans.

23 “(5) GROUP HEALTH PLAN.—For purposes of  
24 this subsection, subsection (d) shall not apply.

1           “(6) APPLICATION TO FEHBP.—Notwith-  
2 standing any other provision of law, the Office of  
3 Personnel Management shall carry out the health  
4 benefits program under chapter 89 of title 5, United  
5 States Code, consistent with the requirements of this  
6 subsection.”.

7           (b) REQUIREMENT OF EQUAL CONTRIBUTIONS TO  
8 ALL FEHBP PLANS.—Section 8906 of title 5, United  
9 States Code, is amended by adding at the end the fol-  
10 lowing:

11           “(j) Notwithstanding subsections (a) through (i), the  
12 Office of Personnel Management shall revise the amount  
13 of the Government contribution made under this section  
14 in a manner so that—

15           “(1) the amount of such contribution does not  
16 change based on the health benefits plan in which  
17 the individual is enrolled; and

18           “(2) the aggregate amount of such contribu-  
19 tions is estimated to be equal to the aggregate  
20 amount of such contributions if this subsection did  
21 not apply.”.

22           (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT  
23 OF 1974 CONFORMING AMENDMENTS.—

24           (1) EXCEPTION FROM HIPAA REQUIREMENTS  
25 FOR BENEFITS PROVIDED UNDER HEALTH CARE



1 CONTRIBUTION ELECTION.—Section 732 of the Em-  
2 ployee Retirement Income Security Act of 1974 (29  
3 U.S.C. 1191a) is amended by adding at the end the  
4 following new subsection:

5 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

6 “(1) IN GENERAL.—The requirements of this  
7 part shall not apply in the case of health insurance  
8 coverage (other than excepted benefits as defined in  
9 section 9832(c) of the Internal Revenue Code of  
10 1986)—

11 “(A) which is provided to a participant or  
12 beneficiary by a health insurance issuer under  
13 a group health plan, and

14 “(B) with respect to which the require-  
15 ments of paragraphs (2) and (3) are met.

16 “(2) CONTRIBUTION ELECTION.—The require-  
17 ment of this paragraph is met with respect to health  
18 insurance coverage provided to a participant or ben-  
19 eficiary by any health insurance issuer under a  
20 group health plan if, under such plan—

21 “(A) the participant may elect such cov-  
22 erage for any period of coverage in lieu of  
23 health insurance coverage otherwise provided  
24 under such plan for such period, and

1           “(B) in the case of such an election, the  
2 plan sponsor is required to pay to such issuer  
3 for the elected coverage for such period an  
4 amount which is not less than the contribution  
5 amount for such health insurance coverage oth-  
6 erwise provided under such plan for such pe-  
7 riod.

8           “(3) PRE-EXISTING CONDITIONS.—

9           “(A) IN GENERAL.—The requirement of  
10 this paragraph is met with respect to health in-  
11 surance coverage provided to a participant or  
12 beneficiary by any health insurance issuer if,  
13 under such plan the requirements of section  
14 701 are met with respect to the participant or  
15 beneficiary.

16           “(B) ENFORCEMENT WITH RESPECT TO  
17 INDIVIDUAL ELECTION.—For purposes of sub-  
18 paragraph (A), any health insurance coverage  
19 with respect to the participant or beneficiary  
20 shall be treated as health insurance coverage  
21 under a group health plan to which section 701  
22 applies.

23           “(4) CONTRIBUTION AMOUNT.—

24           “(A) IN GENERAL.—For purposes of this  
25 section, the term ‘contribution amount’ means,

1 with respect to any period of health insurance  
2 coverage offered to a participant or beneficiary,  
3 the portion of the applicable premium of such  
4 participant or beneficiary under such plan  
5 which is not paid by such participant or bene-  
6 ficiary. In the case that the employer offers  
7 more than one group health plan, the contribu-  
8 tion amount shall be the average amount of the  
9 applicable premiums under such plans.

10 “(B) APPLICABLE PREMIUM.—For pur-  
11 poses of subparagraph (A), the term ‘applicable  
12 premium’ means, with respect to any period of  
13 health insurance coverage of a participant or  
14 beneficiary under a group health plan, the cost  
15 to the plan for such period of such coverage for  
16 similarly situated beneficiaries (without regard  
17 to whether such cost is paid by the plan spon-  
18 sor or the participant or beneficiary).”.

19 (2) EXEMPTION FROM FIDUCIARY LIABILITY.—  
20 Section 404 of such Act (29 U.S.C. 1104) is amend-  
21 ed by adding at the end the following new sub-  
22 section:

23 “(e) The plan sponsor of a group health plan (as de-  
24 fined in section 733(a)) shall not be treated as breaching  
25 any of the responsibilities, obligations, or duties imposed

1 upon fiduciaries by this title in the case of any individual  
2 who is a participant or beneficiary under such plan solely  
3 because of the extent to which the plan sponsor provides,  
4 in the case of such individual, some or all of such benefits  
5 by means of payment of contribution amounts pursuant  
6 to a contribution election under section 732(e), irrespec-  
7 tive of the amount or type of benefits that would otherwise  
8 be provided to such individual under such plan.”.

9 (d) EXCEPTION FROM HIPAA REQUIREMENTS  
10 UNDER IRC FOR BENEFITS PROVIDED UNDER HEALTH  
11 CARE CONTRIBUTION ELECTION.—Section 9831 of the  
12 Internal Revenue Code of 1986 is amended by adding at  
13 the end the following new subsection:

14 “(d) HEALTH CARE CONTRIBUTION ELECTION.—

15 “(1) IN GENERAL.—The requirements of this  
16 chapter shall not apply in the case of health insur-  
17 ance coverage (other than excepted benefits as de-  
18 fined in section 9832(c))—

19 “(A) which is provided to a participant or  
20 beneficiary by a health insurance issuer under  
21 a group health plan, and

22 “(B) with respect to which the require-  
23 ments of paragraphs (2) and (3) are met.

24 “(2) CONTRIBUTION ELECTION.—The require-  
25 ment of this paragraph is met with respect to health

1 insurance coverage provided to a participant or ben-  
2 eficiary by any health insurance issuer under a  
3 group health plan if, under such plan—

4 “(A) the participant may elect such cov-  
5 erage for any period of coverage in lieu of  
6 health insurance coverage otherwise provided  
7 under such plan for such period, and

8 “(B) in the case of such an election, the  
9 plan sponsor is required to pay to such issuer  
10 for the elected coverage for such period an  
11 amount which is not less than the contribution  
12 amount for such health insurance coverage oth-  
13 erwise provided under such plan for such pe-  
14 riod.

15 “(3) PRE-EXISTING CONDITIONS.—

16 “(A) IN GENERAL.—The requirement of  
17 this paragraph is met with respect to health in-  
18 surance coverage provided to a participant or  
19 beneficiary by any health insurance issuer if,  
20 under such plan the requirements of section  
21 9801 are met with respect to the participant or  
22 beneficiary.

23 “(B) ENFORCEMENT WITH RESPECT TO  
24 INDIVIDUAL ELECTION.—For purposes of sub-  
25 paragraph (A), any health insurance coverage

1 with respect to the participant or beneficiary  
2 shall be treated as health insurance coverage  
3 under a group health plan to which section  
4 9801 applies.

5 “(4) CONTRIBUTION AMOUNT.—

6 “(A) IN GENERAL.—For purposes of this  
7 subsection, the term ‘contribution amount’  
8 means, with respect to any period of health in-  
9 surance coverage offered to a participant or  
10 beneficiary, the portion of the applicable pre-  
11 mium of such participant or beneficiary under  
12 such plan which is not paid by such participant  
13 or beneficiary. In the case that the employer of-  
14 fers more than one group health plan, the con-  
15 tribution amount shall be the average amount  
16 of the applicable premiums under such plans.

17 “(B) APPLICABLE PREMIUM.—For pur-  
18 poses of subparagraph (A), the term ‘applicable  
19 premium’ means, with respect to any period of  
20 health insurance coverage of a participant or  
21 beneficiary under a group health plan, the cost  
22 to the plan for such period of such coverage for  
23 similarly situated beneficiaries (without regard  
24 to whether such cost is paid by the plan spon-  
25 sor or the participant or beneficiary).”.

1           (e) EXCEPTION FROM HIPAA REQUIREMENTS  
2 UNDER THE PHSA FOR BENEFITS PROVIDED UNDER  
3 HEALTH CARE CONTRIBUTION ELECTION.—Section 2721  
4 of the Public Health Service Act (42 U.S.C. 300gg–21)  
5 is amended—

6           (1) by redesignating subsection (e) as sub-  
7 section (f); and

8           (2) by inserting after subsection (d) the fol-  
9 lowing new subsection:

10           “(e) HEALTH CARE CONTRIBUTION ELECTION.—

11           “(1) IN GENERAL.—The requirements of sub-  
12 parts 1 through 3 shall not apply in the case of  
13 health insurance coverage (other than excepted bene-  
14 fits as defined in section 9832(c) of the Internal  
15 Revenue Code of 1986)—

16           “(A) which is provided to a participant or  
17 beneficiary by a health insurance issuer under  
18 a group health plan, and

19           “(B) with respect to which the require-  
20 ments of paragraphs (2) and (3) are met.

21           “(2) CONTRIBUTION ELECTION.—The require-  
22 ment of this paragraph is met with respect to health  
23 insurance coverage provided to a participant or ben-  
24 efiary by any health insurance issuer under a  
25 group health plan if, under such plan—

1           “(A) the participant may elect such cov-  
2           erage for any period of coverage in lieu of  
3           health insurance coverage otherwise provided  
4           under such plan for such period, and

5           “(B) in the case of such an election, the  
6           plan sponsor is required to pay to such issuer  
7           for the elected coverage for such period an  
8           amount which is not less than the contribution  
9           amount for such health insurance coverage oth-  
10          erwise provided under such plan for such pe-  
11          riod.

12          “(3) PRE-EXISTING CONDITIONS.—

13                 “(A) IN GENERAL.—The requirement of  
14                 this paragraph is met with respect to health in-  
15                 surance coverage provided to a participant or  
16                 beneficiary by any health insurance issuer if,  
17                 under such plan the requirements of section  
18                 2701 are met with respect to the participant or  
19                 beneficiary.

20                 “(B) ENFORCEMENT WITH RESPECT TO  
21                 INDIVIDUAL ELECTION.—For purposes of sub-  
22                 paragraph (A), any health insurance coverage  
23                 with respect to the participant or beneficiary  
24                 shall be treated as health insurance coverage



1 under a group health plan to which section  
2 2701 applies.

3 “(4) CONTRIBUTION AMOUNT.—

4 “(A) IN GENERAL.—For purposes of this  
5 section, the term ‘contribution amount’ means,  
6 with respect to any period of health insurance  
7 coverage offered to a participant or beneficiary,  
8 the portion of the applicable premium of such  
9 participant or beneficiary under such plan  
10 which is not paid by such participant or bene-  
11 ficiary. In the case that the employer offers  
12 more than one group health plan, the contribu-  
13 tion amount shall be the average amount of the  
14 applicable premiums under such plans.

15 “(B) APPLICABLE PREMIUM.—For pur-  
16 poses of subparagraph (A), the term ‘applicable  
17 premium’ means, with respect to any period of  
18 health insurance coverage of a participant or  
19 beneficiary under a group health plan, the cost  
20 to the plan for such period of such coverage for  
21 similarly situated beneficiaries (without regard  
22 to whether such cost is paid by the plan spon-  
23 sor or the participant or beneficiary).”.

1 **SEC. 135. LIMITATIONS ON STATE RESTRICTIONS ON EM-**  
2 **PLOYER AUTO-ENROLLMENT.**

3 (a) IN GENERAL.—No State shall establish a law  
4 that prevents an employer that is allowed an exclusion  
5 from gross income, a deduction, or a credit for Federal  
6 income tax purposes for health benefits furnished to a par-  
7 ticipant or beneficiary from instituting auto-enrollment  
8 which meets the requirements of subsection (b) for cov-  
9 erage of a participant or beneficiary under a group health  
10 plan, or health insurance coverage offered in connection  
11 with such a plan, so long as the participant or beneficiary  
12 has the option of declining such coverage.

13 (b) AUTOMATIC ENROLLMENT FOR EMPLOYER-  
14 SPONSORED HEALTH BENEFITS.—

15 (1) IN GENERAL.—The requirement of this sub-  
16 section with respect to an employer and an employee  
17 is that the employer automatically enroll such em-  
18 ployee into the employment-based health benefits  
19 plan for individual coverage under the plan option  
20 with the lowest applicable employee premium.

21 (2) OPT-OUT.—In no case may an employer  
22 automatically enroll an employee in a plan under  
23 paragraph (1) if such employee makes an affirmative  
24 election to opt-out of such plan or to elect coverage  
25 under an employment-based health benefits plan of-  
26 fered by such employer. An employer shall provide

1 an employee with a 30-day period to make such an  
2 affirmative election before the employer may auto-  
3 matically enroll the employee in such a plan.

4 (3) NOTICE REQUIREMENTS.—

5 (A) IN GENERAL.—Each employer de-  
6 scribed in paragraph (1) who automatically en-  
7 rolls an employee into a plan as described in  
8 such paragraph shall provide the employees,  
9 within a reasonable period before the beginning  
10 of each plan year (or, in the case of new em-  
11 ployees, within a reasonable period before the  
12 end of the enrollment period for such a new em-  
13 ployee), written notice of the employees' rights  
14 and obligations relating to the automatic enroll-  
15 ment requirement under such paragraph. Such  
16 notice must be comprehensive and understood  
17 by the average employee to whom the automatic  
18 enrollment requirement applies.

19 (B) INCLUSION OF SPECIFIC INFORMA-  
20 TION.—The written notice under subparagraph  
21 (A) must explain an employee's right to opt out  
22 of being automatically enrolled in a plan and in  
23 the case that more than one level of benefits or  
24 employee premium level is offered by the em-  
25 ployer involved, the notice must explain which

1 level of benefits and employee premium level the  
2 employee will be automatically enrolled in the  
3 absence of an affirmative election by the em-  
4 ployee.

5 (c) CONSTRUCTION.—Nothing in this section shall be  
6 construed to supersede State law which establishes, imple-  
7 ments, or continues in effect any standard or requirement  
8 relating to employers in connection with payroll or the  
9 sponsoring of employer-sponsored health insurance cov-  
10 erage except to the extent that such standard or require-  
11 ment prevents an employer from instituting the auto-en-  
12 rollment described in subsection (a).

13 (d) NON-APPLICATION TO EXCEPTED BENEFITS.—  
14 For purposes of this section, the term “group health plan”  
15 does not include excepted benefits (as defined in section  
16 2781(c) of the Public Health Service Act (42 U.S.C.  
17 300gg–91(e))).

18 **SEC. 136. CREDIT FOR SMALL EMPLOYERS ADOPTING**  
19 **AUTO-ENROLLMENT AND DEFINED CON-**  
20 **TRIBUTION OPTIONS.**

21 (a) IN GENERAL.—Subpart D of part IV of sub-  
22 chapter A of chapter 1 of the Internal Revenue Code of  
23 1986, as amended by section 2, is amended by adding at  
24 the end the following new section:

1 **“SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBU-**  
2 **TION OPTION FOR HEALTH BENEFITS PLANS**  
3 **OF SMALL EMPLOYERS.**

4 “(a) IN GENERAL.—For purposes of section 38, in  
5 the case of a small employer, the health benefits plan im-  
6 plementation credit determined under this section for the  
7 taxable year is an amount equal to the amount paid or  
8 incurred by the taxpayer during the taxable year for quali-  
9 fied health benefits expenses.

10 “(b) LIMITATION.—The credit determined under sub-  
11 section (a) with respect to any taxpayer for any taxable  
12 year shall not exceed the excess of—

13 “(1) \$1,500, over

14 “(2) sum of the credits determined under sub-  
15 section (a) with respect to such taxpayer for all pre-  
16 ceding taxable years.

17 “(c) QUALIFIED HEALTH BENEFITS EXPENSES.—  
18 For purposes of this section, the term ‘qualified health  
19 benefits expenses’ means, with respect to any taxable year,  
20 amounts paid or incurred by the taxpayer during such tax-  
21 able year for—

22 “(1) establishing auto-enrollment which meets  
23 the requirements of section x of the short title for  
24 coverage of a participant or beneficiary under a  
25 group health plan, or health insurance coverage of-  
26 fered in connection with such a plan, and

1           “(2) implementing the employer contribution  
2           option for health insurance coverage pursuant to  
3           section 5000(e)(2).

4           “(d) QUALIFIED SMALL EMPLOYER.—For purposes  
5 of this section, the term ‘qualified small employer’ means  
6 any employer for any taxable year if the number of em-  
7 ployees employed by such employer during such taxable  
8 year does not exceed 50. All employers treated as a single  
9 employer under subsection (a) or (b) of section 52 shall  
10 be treated as a single employer for purposes of this sec-  
11 tion.

12          “(e) NO DOUBLE BENEFIT.—No deduction or credit  
13 shall be allowed under any other provision of this chapter  
14 with respect to the amount of the credit determined under  
15 this section.

16          “(f) TERMINATION.—Subsection (a) shall not apply  
17 to any taxable year beginning after the date which is 2  
18 years after the date of the enactment of this section.”.

19          (b) CREDIT TO BE PART OF GENERAL BUSINESS  
20 CREDIT.—Subsection (b) of section 38 of the Internal  
21 Revenue Code of 1986, as amended by section 2, is  
22 amended by striking “plus” at the end of paragraph (34),  
23 by striking the period at the end of paragraph (35) and  
24 inserting “, plus”, and by adding at the end the following  
25 new paragraph:

1           “(36) in the case of a small employer (as de-  
2           fined in section 45R(d)), the health benefits plan im-  
3           plementation credit determined under section  
4           45R(a).”.

5           (c) CLERICAL AMENDMENT.—The table of sections  
6 for subpart D of part IV of subchapter A of chapter 1  
7 of the Internal Revenue Code of 1986, as amended by sec-  
8 tion 2, is amended by inserting after the item relating to  
9 section 45Q the following new item:

          “Sec. 45R. Auto-enrollment and defined contribution option for health benefits  
          plans of small employers.”.

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

13           **TITLE II—HEALTH CARE ACCESS**  
14                           **AND AVAILABILITY**

15           **Subtitle A—Health Insurance Pool-**  
16                   **ing Mechanisms for Individuals**

17           **SEC. 201. FEDERAL GRANTS FOR STATE INSURANCE EX-**  
18                           **PENDITURES.**

19          (a) IN GENERAL.—Subject to the succeeding provi-  
20 sions of this section, each State shall receive from the Sec-  
21 retary of Health and Human Services (in this subtitle re-  
22 ferred to as the “Secretary”) a grant for the State’s pro-  
23 viding for the use, in connection with providing health ben-  
24 efits coverage, of a qualifying high-risk pool or a reinsur-

1 ance pool or other risk-adjustment mechanism used for  
2 the purpose of subsidizing the purchase of private health  
3 insurance.

4 (b) FUNDING AMOUNT.—

5 (1) IN GENERAL.—There are hereby appro-  
6 priated, out of any funds in the Treasury not other-  
7 wise appropriated, \$1,000,000,000 for each of fiscal  
8 years 2016, 2017, and 2018 for grants under this  
9 section. Such amount shall be divided among the  
10 States as determined by the Secretary.

11 (2) CONSTRUCTION.—Nothing in this section  
12 shall be construed as preventing a State from using  
13 funding under section 2745 of the Public Health  
14 Service Act for purposes of funding reinsurance or  
15 other risk mechanisms.

16 (c) LIMITATION.—Funding under subsection (a) may  
17 only be used for the following:

18 (1) QUALIFYING HIGH-RISK POOLS.—

19 (A) CURRENT POOLS.—A qualifying high-  
20 risk pool created before the date of the enact-  
21 ment of this Act that only covers high-risk pop-  
22 ulations and individuals (and their spouse and  
23 dependents) receiving a health care tax credit  
24 under section 35 of the Internal Revenue Code  
25 of 1986 for a limited period of time as deter-



1           mined by the Secretary or under section 2741  
2           of Public Health Service Act.

3           (B) NEW POOLS.—A qualifying high-risk  
4           pool created on or after such date that only cov-  
5           ers populations and individuals described in  
6           subparagraph (A) if the pool—

7                   (i) offers at least the option of one or  
8                   more high-deductible plan options, in com-  
9                   bination with a contribution into a health  
10                  savings account;

11                  (ii) offers multiple competing health  
12                  plan options; and

13                  (iii) covers only high-risk populations.

14           (2) RISK INSURANCE POOL OR OTHER RISK-AD-  
15           JUSTMENT MECHANISMS.—

16           (A) CURRENT REINSURANCE.—A reinsur-  
17           ance pool, or other risk-adjustment mechanism,  
18           created before the date of the enactment of this  
19           Act that only covers populations and individuals  
20           described in paragraph (1)(A).

21           (B) NEW POOLS.—A reinsurance pool or  
22           other risk-adjustment mechanism created on or  
23           after such date that provides reinsurance only  
24           covers populations and individuals described in  
25           paragraph (1)(A) and only on a prospective

1           basis under which a health insurance issuer  
2           cedes covered lives to the pool in exchange for  
3           payment of a reinsurance premium.

4           (3) TRANSITION.—Nothing in this section shall  
5           be construed as preventing a State from using funds  
6           available to transition from an existing high-risk  
7           pool to a reinsurance pool.

8           (d) BONUS PAYMENTS.—With respect to any  
9           amounts made available to the States under this section,  
10          the Secretary shall set aside a portion of such amounts  
11          that shall only be available for the following activities by  
12          such States:

13           (1) Providing guaranteed availability of indi-  
14           vidual health insurance coverage to certain individ-  
15           uals with prior group coverage under part B of title  
16           XXVII of the Public Health Service Act.

17           (2) A reduction in premium trends, actual pre-  
18           miums, or other cost-sharing requirements.

19           (3) An expansion or broadening of the pool of  
20           high-risk individuals eligible for coverage.

21           (4) States that adopt the Model Health Plan  
22           for Uninsurable Individuals Act of the National As-  
23           sociation of Insurance Commissioners (if and when  
24           updated by such Association).

1 The Secretary may request such Association to update  
2 such Model Health Plan as needed by 2015.

3 (e) REQUIREMENTS FOR RECEIPT OF BONUS PAY-  
4 MENTS.—The requirements of this subsection, for the  
5 availability of bonus payments to a State under subsection  
6 (d), are as follows, in the case of an individual who is cov-  
7 ered under a high-risk pool or other pool or mechanism  
8 described in subsection (b) operating in the State for  
9 which funds under this section may be applied:

10 (1) LIMITATION ON ANNUAL PREMIUMS FOR  
11 EACH INDIVIDUAL BASED ON ADJUSTED GROSS FAM-  
12 ILY INCOME.—The premiums imposed for coverage  
13 of each individual under health insurance coverage  
14 offered through such pool or mechanism may not ex-  
15 ceed (on an annual basis) the following:

16 (A) If the adjusted gross income (as de-  
17 fined in section 62 of the Internal Revenue  
18 Code of 1986) of all individuals in the individ-  
19 ual's family does not exceed the poverty line (as  
20 defined in section 673(2) of the Community  
21 Services Block Grant Act (42 U.S.C. 9902(2)),  
22 including any revision required by such section)  
23 applicable to a family of the size involved, 2  
24 percent of such income.

1 (B) If such adjusted gross income for all  
2 individuals in the individual's family exceeds  
3 such applicable poverty line, the sum of—

4 (i) 2 percent of such applicable pov-  
5 erty line; and

6 (ii) 10 percent of the amount of such  
7 income that exceeds such applicable pov-  
8 erty line.

9 (2) LIMITATION ON ANNUAL OUT-OF-POCKET  
10 COSTS FOR EACH INDIVIDUAL.—There shall be a  
11 limit on the annual out-of-pocket expenditures (in-  
12 cluding annual premiums) for each individual for  
13 coverage under such pool or mechanism equal to  
14 twice the maximum allowable premiums for such in-  
15 dividual permitted under paragraph (1).

16 (f) ADMINISTRATION.—The Secretary shall provide  
17 for the administration of this section and may establish  
18 such terms and conditions, including the requirement of  
19 an application, as may be appropriate to carry out this  
20 section.

21 (g) CONSTRUCTION.—Nothing in this section shall be  
22 construed as requiring a State to operate a reinsurance  
23 pool (or other risk-adjustment mechanism) under this sec-  
24 tion or as preventing a State from operating such a pool  
25 or mechanism through one or more private entities.

1 (h) DEFINITIONS.—In this section:

2 (1) QUALIFYING HIGH-RISK POOL.—The term  
3 “qualifying high-risk pool” means any qualified  
4 high-risk pool (as defined in subsection (g)(1)(A) of  
5 section 2745 of the Public Health Service Act) that  
6 meets the conditions to receive a grant under section  
7 (b)(1) of such section.

8 (2) REINSURANCE POOL OR OTHER RISK-AD-  
9 JUSTMENT MECHANISM DEFINED.—The term “rein-  
10 surance pool or other risk-adjustment mechanism”  
11 means any State-based risk spreading mechanism to  
12 subsidize the purchase of private health insurance  
13 for the high-risk population.

14 (3) HIGH-RISK POPULATION.—The term “high-  
15 risk population” means—

16 (A) individuals who, by reason of the exist-  
17 ence or history of a medical condition, are able  
18 to acquire health coverage only at rates which  
19 are at least 150 percent of the standard risk  
20 rates for such coverage (in a non-community-  
21 rated non-guaranteed issue State), and

22 (B) individuals who are provided health  
23 coverage by a high-risk pool.

24 (4) STATE DEFINED.—The term “State” in-  
25 cludes the District of Columbia, Puerto Rico, the

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

3 (i) EXTENDING FUNDING.—Section 2745(d)(2) of  
4 the Public Health Service Act (42 U.S.C. 300gg–45(d)(2))  
5 is amended—

6 (1) in the heading, by inserting “AND 2016  
7 THROUGH 2018” after “2010”; and

8 (2) by inserting “and for each of fiscal years  
9 2016 through 2018” after “for each of fiscal years  
10 2007 through 2010”.

11 (j) SUNSET.—Funds made available under this sec-  
12 tion shall not be used for the purpose of subsidizing the  
13 purchase of private health insurance on or after October  
14 1, 2018.

15 **SEC. 202. POOL REFORM FOR INDIVIDUAL MEMBERSHIP**  
16 **EXPANSION.**

17 The Public Health Service Act, as amended by sec-  
18 tion 2, is further amended by inserting after title XXX  
19 the following new title:

20 **“TITLE XXXI—POOL REFORM**  
21 **FOR INDIVIDUAL MEMBER-**  
22 **SHIP EXPANSION**

23 **“SEC. 3100. PURPOSE.**

24 “The purpose of this title is to provide, through the  
25 establishment of independent health pools (referred to in

1 this title as ‘IHP’), for the reform of, and expansion of  
2 enrollment in, health insurance coverage for individuals  
3 and small employers.

4 **“SEC. 3101. DEFINITION OF INDEPENDENT HEALTH POOL.**

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

8 “(1) ORGANIZATION.—The IHP—

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

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

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

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

21 “(E) does not receive any consideration di-  
22 rectly or indirectly from any health insurance  
23 issuer in connection with the enrollment of any  
24 individuals, or employees of employers, in any

1 health insurance coverage, except in conjunction  
2 with services offered through the IHP.

3 “(2) OFFERING HEALTH BENEFITS COV-  
4 ERAGE.—

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

18 “(B) NONDISCRIMINATION IN COVERAGE  
19 OFFERED.—

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



1           “(ii) CONSTRUCTION.—Nothing in  
2           this title shall be construed as requiring or  
3           permitting a health insurance issuer to  
4           provide coverage outside the service area of  
5           the issuer, as approved under State law, or  
6           preventing a health insurance issuer from  
7           underwriting or from excluding or limiting  
8           the coverage on any individual, subject to  
9           the requirement of section 2741 (relating  
10          to guaranteed availability of individual  
11          health insurance coverage to certain indi-  
12          viduals with prior group coverage).

13          “(C) NO ASSUMPTION OF INSURANCE RISK  
14          BY IHP.—The IHP provides health benefits cov-  
15          erage only through contracts with health insur-  
16          ance issuers and does not assume insurance  
17          risk with respect to such coverage.

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

23          “(4) PROVISION OF ADMINISTRATIVE SERVICES  
24          TO PURCHASERS.—The IHP may provide adminis-  
25          trative services for members. Such services may in-

1       clude accounting, billing, and enrollment informa-  
2       tion.

3       “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
4       MENTS.—

5               “(1) COMPLIANCE WITH CONSUMER PROTEC-  
6       TION REQUIREMENTS.—Except as provided in sec-  
7       tion 3102, any health benefits coverage offered  
8       through an IHP—

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

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

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

16              “(2) WELLNESS BONUSES FOR HEALTH PRO-  
17       MOTION.—Nothing in this title shall be construed as  
18       precluding a health insurance issuer offering health  
19       benefits coverage through an IHP from establishing  
20       premium discounts or rebates for members or from  
21       modifying otherwise applicable copayments or  
22       deductibles in return for adherence to programs of  
23       health promotion and disease prevention so long as  
24       such programs are agreed to in advance by the IHP  
25       and comply with all other provisions of this title and

1 do not discriminate among similarly situated mem-  
2 bers.

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

4 “(1) MEMBERS.—

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

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

22 “(2) HEALTH INSURANCE ISSUERS.—The con-  
23 tract between an IHP and a health insurance issuer  
24 shall provide, with respect to a member enrolled with  
25 health benefits coverage offered by the issuer

1 through the IHP, for the payment to the issuer of  
2 the premiums (if any) collected by the IHP for  
3 health insurance coverage offered by the issuer.

4 **“SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
5 **MENTS.**

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

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

13 “(1) BENEFIT REQUIREMENTS.—

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

23 “(B) EXCEPTION FOR FEDERALLY IM-  
24 POSED REQUIREMENTS AND FOR REQUIRE-  
25 MENTS PROHIBITING DISEASE-SPECIFIC EXCLU-

1           SIONS.—Subparagraph (A) shall not apply to a  
2           requirement to the extent the requirement—

3                   “(i) implements title XXVII or other  
4                   Federal law; or

5                   “(ii) prohibits imposition of an exclu-  
6                   sion of a specific disease from health bene-  
7                   fits coverage.

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

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

24          **“SEC. 3103. DEFINITIONS.**

25          “For purposes of this title:

1           “(1) DEPENDENT.—The term ‘dependent’, as  
2 applied to health insurance coverage offered by a  
3 health insurance issuer licensed (or otherwise regu-  
4 lated) in a State, shall have the meaning applied to  
5 such term with respect to such coverage under the  
6 laws of the State relating to such coverage and such  
7 an issuer. Such term may include the spouse and  
8 children of the individual involved.

9           “(2) HEALTH BENEFITS COVERAGE.—The term  
10 ‘health benefits coverage’ has the meaning given the  
11 term health insurance coverage in section  
12 2791(b)(1), and does not include excepted benefits  
13 (as defined in section 2791(c)).

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

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

20           “(5) MEMBER.—The term ‘member’ means,  
21 with respect to an IHP, an individual or small em-  
22 ployer who is a member of the legal entity described  
23 in section 3101(a)(1) to which the IHP is offering  
24 coverage.



1 purpose and providing for periodic meetings on at  
2 least an annual basis, as a bona fide trade associa-  
3 tion, a bona fide industry association (including a  
4 rural electric cooperative association or a rural tele-  
5 phone cooperative association), a bona fide profes-  
6 sional association, or a bona fide chamber of com-  
7 merce (or similar bona fide business association, in-  
8 cluding a corporation or similar organization that  
9 operates on a cooperative basis (within the meaning  
10 of section 1381 of the Internal Revenue Code of  
11 1986)), for substantial purposes other than that of  
12 obtaining or providing medical care;

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

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



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

5 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
6 **PLANS.**

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

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

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

1 of certification (or, if later, on the date on which the plan  
2 is to commence operations).

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

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

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

22 “(1) a plan which offered such coverage on the  
23 date of the enactment of the Small Business Health  
24 Fairness Act of 2015;

1           “(2) a plan under which the sponsor does not  
2           restrict membership to one or more trades and busi-  
3           nesses or industries and whose eligible participating  
4           employers represent a broad cross-section of trades  
5           and businesses or industries; or

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

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

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

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

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

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

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

26 “(A) BOARD MEMBERSHIP.—

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

9           “(ii) LIMITATION.—

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

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

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

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

12 “(iii) CERTAIN PLANS EXCLUDED.—  
13 Clause (i) shall not apply to an association  
14 health plan which is in existence on the  
15 date of the enactment of the Small Busi-  
16 ness Health Fairness Act of 2015.

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

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



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

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

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

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

19       “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
20       PLOYEES.—In the case of an association health plan in  
21       existence on the date of the enactment of the Small Busi-  
22       ness Health Fairness Act of 2015, an affiliated member  
23       of the sponsor of the plan may be offered coverage under  
24       the plan as a participating employer only if—



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21          “(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

11 “(1) \$500,000; or

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

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

15           “(B) which is guaranteed renewable; and

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

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

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

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

6                   “(B) which is guaranteed renewable; and

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

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

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

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

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

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

7       “(j) SOLVENCY STANDARDS WORKING GROUP.—

8           “(1) IN GENERAL.—Within 90 days after the  
9 date of the enactment of the Small Business Health  
10 Fairness Act of 2015, the applicable authority shall  
11 establish a Solvency Standards Working Group. In  
12 prescribing the initial regulations under this section,  
13 the applicable authority shall take into account the  
14 recommendations of such Working Group.

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

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

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



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

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

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

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

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

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

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

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

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

5                   “(A) the sponsor; and

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

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

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

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

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

1 plan and contract administrators and other service  
2 providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 pants and beneficiaries and providers of medical  
2 care.

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

6 “(1) the sponsor and plan administrator;

7 “(2) each participant;

8 “(3) each participating employer; and

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

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

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

1 “(f) JURISDICTION OF COURT.—

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

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

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

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

15          “(a) IN GENERAL.—Notwithstanding section 514, a  
16          State may impose by law a contribution tax on an associa-  
17          tion health plan described in section 806(a)(2), if the plan  
18          commenced operations in such State after the date of the  
19          enactment of the Small Business Health Fairness Act of  
20          2015.

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

1           “(1) such tax is computed by applying a rate to  
2           the amount of premiums or contributions, with re-  
3           spect to individuals covered under the plan who are  
4           residents of such State, which are received by the  
5           plan from participating employers located in such  
6           State or from such individuals;

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

13          “(3) such tax is otherwise nondiscriminatory;  
14          and

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



1       vided by such insurers or health maintenance organi-  
2       zations in such State in connection with such plan.

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

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

5               “(1) GROUP HEALTH PLAN.—The term ‘group  
6       health plan’ has the meaning provided in section  
7       733(a)(1) (after applying subsection (b) of this sec-  
8       tion).

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

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

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

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

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

4           “(7) INDIVIDUAL MARKET.—

5           “(A) IN GENERAL.—The term ‘individual  
6 market’ means the market for health insurance  
7 coverage offered to individuals other than in  
8 connection with a group health plan.

9           “(B) TREATMENT OF VERY SMALL  
10 GROUPS.—

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

18           “(ii) STATE EXCEPTION.—Clause (i)  
19 shall not apply in the case of health insur-  
20 ance coverage offered in a State if such  
21 State regulates the coverage described in  
22 such clause in the same manner and to the  
23 same extent as coverage in the small group  
24 market (as defined in section 2791(e)(5) of

1           the Public Health Service Act) is regulated  
2           by such State.

3           “(8) PARTICIPATING EMPLOYER.—The term  
4           ‘participating employer’ means, in connection with  
5           an association health plan, any employer, if any indi-  
6           vidual who is an employee of such employer, a part-  
7           ner in such employer, or a self-employed individual  
8           who is such employer (or any dependent, as defined  
9           under the terms of the plan, of such individual) is  
10          or was covered under such plan in connection with  
11          the status of such individual as such an employee,  
12          partner, or self-employed individual in relation to the  
13          plan.

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

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

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

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

6                   “(B) in the case of a sponsor with mem-  
7                   bers which consist of associations, a person who  
8                   is a member of any such association and elects  
9                   an affiliated status with the sponsor, or

10                  “(C) in the case of an association health  
11                  plan in existence on the date of the enactment  
12                  of the Small Business Health Fairness Act of  
13                  2015, a person eligible to be a member of the  
14                  sponsor or one of its member associations.

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

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

1 “(b) RULES OF CONSTRUCTION.—

2 “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
3 poses of determining whether a plan, fund, or pro-  
4 gram is an employee welfare benefit plan which is an  
5 association health plan, and for purposes of applying  
6 this title in connection with such plan, fund, or pro-  
7 gram so determined to be such an employee welfare  
8 benefit plan—

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

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

19 “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
20 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
21 case of any plan, fund, or program which was estab-  
22 lished or is maintained for the purpose of providing  
23 medical care (through the purchase of insurance or  
24 otherwise) for employees (or their dependents) cov-  
25 ered thereunder and which demonstrates to the Sec-

1       retary that all requirements for certification under  
2       this part would be met with respect to such plan,  
3       fund, or program if such plan, fund, or program  
4       were a group health plan, such plan, fund, or pro-  
5       gram shall be treated for purposes of this title as an  
6       employee welfare benefit plan on and after the date  
7       of such demonstration.

8               “(3) EXCEPTION FOR CERTAIN BENEFITS.—  
9       The requirements of this part shall not apply to a  
10      group health plan in relation to its provision of ex-  
11      cepted benefits, as defined in section 706(c).”.

12      (b) CONFORMING AMENDMENTS TO PREEMPTION  
13      RULES.—

14              (1) Section 514(b)(6) of such Act (29 U.S.C.  
15      1144(b)(6)) is amended by adding at the end the  
16      following new subparagraph:

17              “(E) The preceding subparagraphs of this paragraph  
18      do not apply with respect to any State law in the case  
19      of an association health plan which is certified under part  
20      8.”.

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

23                      (A) in subsection (b)(4), by striking “Sub-  
24                      section (a)” and inserting “Subsections (a) and  
25                      (d)”;

1 (B) in subsection (b)(5), by striking “sub-  
2 section (a)” in subparagraph (A) and inserting  
3 “subsection (a) of this section and subsections  
4 (a)(2)(B) and (b) of section 805”, and by strik-  
5 ing “subsection (a)” in subparagraph (B) and  
6 inserting “subsection (a) of this section or sub-  
7 section (a)(2)(B) or (b) of section 805”;

8 (C) by redesignating subsection (d) as sub-  
9 section (e); and

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

12 “(d)(1) Except as provided in subsection (b)(4), the  
13 provisions of this title shall supersede any and all State  
14 laws insofar as they may now or hereafter preclude, or  
15 have the effect of precluding, a health insurance issuer  
16 from offering health insurance coverage in connection with  
17 an association health plan which is certified under part  
18 8.

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

21 “(A) In any case in which health insurance cov-  
22 erage of any policy type is offered under an associa-  
23 tion health plan certified under part 8 to a partici-  
24 pating employer operating in such State, the provi-  
25 sions of this title shall supersede any and all laws

1 of such State insofar as they may preclude a health  
2 insurance issuer from offering health insurance cov-  
3 erage of the same policy type to other employers op-  
4 erating in the State which are eligible for coverage  
5 under such association health plan, whether or not  
6 such other employers are participating employers in  
7 such plan.

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

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



1           “(A) providing solvency standards or similar  
2 standards regarding the adequacy of insurer capital,  
3 surplus, reserves, or contributions, or

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

5           “(4) For additional provisions relating to association  
6 health plans, see subsections (a)(2)(B) and (b) of section  
7 805.

8           “(5) For purposes of this subsection, the term ‘asso-  
9 ciation health plan’ has the meaning provided in section  
10 801(a), and the terms ‘health insurance coverage’, ‘par-  
11 ticipating employer’, and ‘health insurance issuer’ have  
12 the meanings provided such terms in section 812, respec-  
13 tively.”.

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

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

18           (B) in clause (ii)—

19           (i) by inserting “and which does not  
20 provide medical care (within the meaning  
21 of section 733(a)(2)),” after “arrange-  
22 ment,”; and

23           (ii) by striking “title.” and inserting  
24 “title, and”; and

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

3 “(iii) subject to subparagraph (E), in the case  
4 of any other employee welfare benefit plan which is  
5 a multiple employer welfare arrangement and which  
6 provides medical care (within the meaning of section  
7 733(a)(2)), any law of any State which regulates in-  
8 surance may apply.”.

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

11 (A) by striking “Nothing” and inserting  
12 “(1) Except as provided in paragraph (2), noth-  
13 ing”; and

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

16 “(2) Nothing in any other provision of law enacted  
17 on or after the date of the enactment of the Small Busi-  
18 ness Health Fairness Act of 2015 shall be construed to  
19 alter, amend, modify, invalidate, impair, or supersede any  
20 provision of this title, except by specific cross-reference to  
21 the affected section.”.

22 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
23 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
24 the following new sentence: “Such term also includes a

1 person serving as the sponsor of an association health plan  
2 under part 8.”.

3 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-  
4 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS  
5 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)  
6 of such Act (29 U.S.C. 1022(b)) is amended by adding  
7 at the end the following: “An association health plan shall  
8 include in its summary plan description, in connection  
9 with each benefit option, a description of the form of sol-  
10 vency or guarantee fund protection secured pursuant to  
11 this Act or applicable State law, if any.”.

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

1 **SEC. 213. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 2 **PLOYER ARRANGEMENTS.**

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

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

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

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

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

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

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

20                 “(iv) in any case in which the benefit referred  
21                 to in subparagraph (A) consists of medical care (as  
22                 defined in section 812(a)(2)), in determining, after  
23                 the application of clause (i), whether benefits are  
24                 provided to employees of 2 or more employers, the  
25                 arrangement shall be treated as having only one par-

1        participating employer if, after the application of clause  
2        (i), the number of individuals who are employees and  
3        former employees of any one participating employer  
4        and who are covered under the arrangement is  
5        greater than 75 percent of the aggregate number of  
6        all individuals who are employees or former employ-  
7        ees of participating employers and who are covered  
8        under the arrangement.”.

9        **SEC. 214. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
10        **CIATION HEALTH PLANS.**

11        (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
12 MISREPRESENTATIONS.—Section 501 of the Employee  
13 Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
14 is amended—

15                (1) by inserting “(a)” after “Sec. 501.”; and

16                (2) by adding at the end the following new sub-  
17 section:

18        “(b) Any person who willfully falsely represents, to  
19 any employee, any employee’s beneficiary, any employer,  
20 the Secretary, or any State, a plan or other arrangement  
21 established or maintained for the purpose of offering or  
22 providing any benefit described in section 3(1) to employ-  
23 ees or their beneficiaries as—

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

1           “(2) having been established or maintained  
2           under or pursuant to one or more collective bar-  
3           gaining agreements which are reached pursuant to  
4           collective bargaining described in section 8(d) of the  
5           National Labor Relations Act (29 U.S.C. 158(d)) or  
6           paragraph Fourth of section 2 of the Railway Labor  
7           Act (45 U.S.C. 152, paragraph Fourth) or which are  
8           reached pursuant to labor-management negotiations  
9           under similar provisions of State public employee re-  
10          lations laws; or

11           “(3) being a plan or arrangement described in  
12          section 3(40)(A)(i),  
13 shall, upon conviction, be imprisoned not more than 5  
14 years, be fined under title 18, United States Code, or  
15 both.”.

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

19          “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-  
20 SIST ORDERS.—

21           “(1) IN GENERAL.—Subject to paragraph (2),  
22           upon application by the Secretary showing the oper-  
23           ation, promotion, or marketing of an association  
24           health plan (or similar arrangement providing bene-

1 fits consisting of medical care (as defined in section  
2 733(a)(2))) that—

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

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

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

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

20 “(A) all benefits under it referred to in  
21 paragraph (1) consist of health insurance cov-  
22 erage; and

23 “(B) with respect to each State in which  
24 the plan or arrangement offers or provides ben-  
25 efits, the plan or arrangement is operating in





1       “(d) CONSULTATION WITH STATES WITH RESPECT  
2 TO ASSOCIATION HEALTH PLANS.—

3           “(1) AGREEMENTS WITH STATES.—The Sec-  
4 retary shall consult with the State recognized under  
5 paragraph (2) with respect to an association health  
6 plan regarding the exercise of—

7           “(A) the Secretary’s authority under sec-  
8 tions 502 and 504 to enforce the requirements  
9 for certification under part 8; and

10          “(B) the Secretary’s authority to certify  
11 association health plans under part 8 in accord-  
12 ance with regulations of the Secretary applica-  
13 ble to certification under part 8.

14          “(2) RECOGNITION OF PRIMARY DOMICILE  
15 STATE.—In carrying out paragraph (1), the Sec-  
16 retary shall ensure that only one State will be recog-  
17 nized, with respect to any particular association  
18 health plan, as the State with which consultation is  
19 required. In carrying out this paragraph—

20          “(A) in the case of a plan which provides  
21 health insurance coverage (as defined in section  
22 812(a)(3)), such State shall be the State with  
23 which filing and approval of a policy type of-  
24 fered by the plan was initially obtained; and

1           “(B) in any other case, the Secretary shall  
2           take into account the places of residence of the  
3           participants and beneficiaries under the plan  
4           and the State in which the trust is main-  
5           tained.”.

6 **SEC. 216. EFFECTIVE DATE AND TRANSITIONAL AND**  
7           **OTHER RULES.**

8           (a) **EFFECTIVE DATE.**—The amendments made by  
9           this subtitle shall take effect 1 year after the date of the  
10          enactment of this Act. The Secretary of Labor shall first  
11          issue all regulations necessary to carry out the amend-  
12          ments made by this subtitle within 1 year after the date  
13          of the enactment of this Act.

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

16               (1) **IN GENERAL.**—In any case in which, as of  
17               the date of the enactment of this Act, an arrange-  
18               ment is maintained in a State for the purpose of  
19               providing benefits consisting of medical care for the  
20               employees and beneficiaries of its participating em-  
21               ployers, at least 200 participating employers make  
22               contributions to such arrangement, such arrange-  
23               ment has been in existence for at least 10 years, and  
24               such arrangement is licensed under the laws of one  
25               or more States to provide such benefits to its par-

1        participating employers, upon the filing with the appli-  
2        cable authority (as defined in section 812(a)(5) of  
3        the Employee Retirement Income Security Act of  
4        1974 (as amended by this subtitle)) by the arrange-  
5        ment of an application for certification of the ar-  
6        rangement under part 8 of subtitle B of title I of  
7        such Act—

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

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

15               (C) the requirements of section 803(b) of  
16               such Act shall be deemed met, if the arrange-  
17               ment is operated by a board of directors  
18               which—

19                        (i) is elected by the participating em-  
20                        ployers, with each employer having one  
21                        vote; and

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

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

4           (E) the arrangement may be certified by  
5 any applicable authority with respect to its op-  
6 erations in any State only if it operates in such  
7 State on the date of certification.

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

13           (2) DEFINITIONS.—For purposes of this sub-  
14 section, the terms “group health plan”, “medical  
15 care”, and “participating employer” shall have the  
16 meanings provided in section 812 of the Employee  
17 Retirement Income Security Act of 1974, except  
18 that the reference in paragraph (7) of such section  
19 to an “association health plan” shall be deemed a  
20 reference to an arrangement referred to in this sub-  
21 section.

1           **Subtitle C—Health Insurance**  
 2                           **Reforms**

3   **SEC. 221. REQUIREMENTS FOR INDIVIDUAL HEALTH INSUR-**  
 4                           **ANCE.**

5           (a) IN GENERAL.—Section 2741 of the Public Health  
 6 Service Act (42 U.S.C. 300gg–41), as restored and revived  
 7 by section 2 of this Act, is amended—

8                   (1) in subsection (a)—

9                           (A) in the heading, by striking “**TO CER-**  
 10                           **TAIN INDIVIDUALS WITH PRIOR GROUP**  
 11                           **COVERAGE**”;

12                           (B) in paragraph (1), by striking “and sec-  
 13                           tion 2744”;

14                           (C) in paragraph (1)(B), by inserting “un-  
 15                           less such exclusion complies with paragraph  
 16                           (2)” before the period; and

17                           (D) by striking paragraph (2) and insert-  
 18                           ing the following new paragraphs:

19                           “(2) **LIMITATION ON PREEXISTING CONDITION**  
 20                           **EXCLUSION PERIOD.—**

21                           “(A) **LIMITATION.—**A health insurance  
 22                           issuer offering health insurance coverage in the  
 23                           individual market may not, with respect to an  
 24                           enrollee in such coverage, impose any pre-  
 25                           existing condition exclusion if such enrollee has

1 at least 18 months of continuous creditable cov-  
2 erage (as defined in section 2701(c)(1)) imme-  
3 diately preceding the enrollment date.

4 “(B) IMPOSITION OF EXCLUSION.—Not-  
5 withstanding paragraph (1)(B), a health insur-  
6 ance issuer offering health insurance coverage  
7 in the individual market may, with respect to  
8 an enrollee in such coverage who is not de-  
9 scribed in subparagraph (A), impose a pre-  
10 existing condition exclusion only if—

11 “(i) such exclusion relates to a condi-  
12 tion (whether physical or mental), regard-  
13 less of the cause of the condition, for which  
14 medical advice, diagnosis, care, or treat-  
15 ment was recommended or received within  
16 the 6-month period ending on the enroll-  
17 ment date;

18 “(ii) such exclusion extends for a pe-  
19 riod of not more than 18 months after the  
20 enrollment date; and

21 “(iii) the period of any such pre-  
22 existing condition exclusion is reduced by  
23 the aggregate of the periods of creditable  
24 coverage (if any, as defined in section

1           2701(c)(1)) applicable to the enrollee as of  
2           the enrollment date.

3           “(C) PREMIUM SURCHARGE.—Notwith-  
4           standing paragraph (6), with respect to an en-  
5           rollee described in subparagraph (B), a health  
6           insurance issuer may charge a premium for the  
7           coverage involved that does not exceed 150 per-  
8           cent of the applicable standard rate, for not to  
9           exceed 2 years (or 3 years if the health insur-  
10          ance issuer does not impose any preexisting  
11          condition exclusion with respect to such en-  
12          rollee), reduced by the aggregate of the periods  
13          of creditable coverage (if any, as defined in sec-  
14          tion 2701(c)(1)) applicable to the enrollee as of  
15          the enrollment date. For purposes of this sub-  
16          section, the term ‘applicable standard rate’  
17          means the standard premium rate that the  
18          issuer charges for the coverage involved with re-  
19          spect to an individual described in subpara-  
20          graph (A) with the same rating characteristics  
21          or rating factors as the enrollee described in  
22          subparagraph (B), provided that any variations  
23          in standard premium rates are based on the  
24          uniform application of rating characteristics or  
25          rating factors that are permitted by State law



1 and are not otherwise prohibited by paragraph  
2 (6).

3 “(3) EXCEPTIONS.—Notwithstanding para-  
4 graph (2), and subject to subparagraph (D), a  
5 health insurance issuer offering health insurance  
6 coverage in the individual market, may not impose  
7 any of the following preexisting condition exclusion:

8 “(A) EXCLUSION NOT APPLICABLE TO  
9 CERTAIN NEWBORNS.—In the case of an indi-  
10 vidual who, as of the last day of the 30-day pe-  
11 riod beginning with the date of birth, is a de-  
12 pendent of an enrollee in such coverage.

13 “(B) EXCLUSION NOT APPLICABLE TO  
14 CERTAIN ADOPTED CHILDREN.—In the case of  
15 a child who is adopted or placed for adoption  
16 before attaining 18 years of age and who, as of  
17 the last day of the 30-day period beginning on  
18 the date of the adoption or placement for adop-  
19 tion, is a dependent of an enrollee in such cov-  
20 erage. The previous sentence shall not apply to  
21 coverage before the date of such adoption or  
22 placement for adoption.

23 “(C) EXCLUSION NOT APPLICABLE TO  
24 PREGNANCY.—Relating to pregnancy as a pre-  
25 existing condition.

1           “(D) LOSS IF BREAK IN COVERAGE.—Sub-  
2 paragraphs (A) and (B) shall no longer apply  
3 to an individual after the end of the first 63-  
4 day period during all of which the individual  
5 was not covered under any creditable coverage.

6           “(4) OPEN ENROLLMENT PERIODS.—A health  
7 insurance issuer offering health insurance coverage  
8 in the individual market may limit the applicability  
9 of the provisions of paragraph (1) to scheduled open  
10 enrollment periods, provided that—

11           “(A) any such open enrollment period shall  
12 not be less than 30 days;

13           “(B) any period between scheduled open  
14 enrollment periods shall not exceed 24 months;  
15 and

16           “(C) such limitation shall not apply to any  
17 individual who qualifies for a special enrollment  
18 period under paragraph (5).

19           “(5) SPECIAL ENROLLMENT PERIODS.—

20           “(A) IN GENERAL.—Subject to subpara-  
21 graphs (B) and (C), a health insurance issuer  
22 offering health insurance coverage in the indi-  
23 vidual market shall permit an individual who is  
24 an eligible individual or a dependent to enroll in  
25 coverage during a special enrollment period if

1 the individual experiences any of the following  
2 qualifying events:

3 “(i) FOR DEPENDENT BENE-  
4 FICIARIES.—The individual becomes, by  
5 reason of marriage, birth, adoption or  
6 placement for adoption, a dependent of an  
7 individual enrolled in a plan offered by the  
8 health insurance issuer and such individual  
9 otherwise qualifies, under the terms of the  
10 plan, as eligible for coverage as a depend-  
11 ent of such enrollee.

12 “(ii) LOSS OF GROUP COVERAGE.—  
13 The individual loses coverage under a  
14 group health plan as a result of—

15 “(I) loss of eligibility for the cov-  
16 erage (including as a result of legal  
17 separation, divorce, death, attaining  
18 an age at which eligibility terminates,  
19 termination of employment, or reduc-  
20 tion in the number of hours of em-  
21 ployment); or

22 “(II) termination of the coverage  
23 by the plan sponsor.

1           “(iii) LOSS OF INDIVIDUAL COV-  
2 ERAGE.—The individual loses individual  
3 market coverage as a result of—

4           “(I) discontinuation of a plan as  
5 a result of a health insurance issuer  
6 ceasing to offer coverage in the indi-  
7 vidual market in accordance with sec-  
8 tion 2742(c)(2);

9           “(II) expiration of COBRA, or  
10 other, continuation coverage;

11           “(III) ceasing to qualify, under  
12 the terms of the coverage, as a de-  
13 pendent (including as a result of legal  
14 separation, divorce, death, or attain-  
15 ing an age at which eligibility termi-  
16 nates); or

17           “(IV) permanently moving out-  
18 side the State in which the coverage  
19 was issued, or in the case of a net-  
20 work plan, outside the plan’s service  
21 area.

22           “(iv) LOSS OF ELIGIBILITY FOR A  
23 GOVERNMENT COVERAGE PROGRAM.—The  
24 individual loses coverage by ceasing to be

1 eligible for coverage under any of the fol-  
2 lowing:

3 “(I) Part A or part B of title  
4 XVIII of the Social Security Act.

5 “(II) Title XIX of the Social Se-  
6 curity Act, other than coverage con-  
7 sisting solely of benefits under section  
8 1928 of such title.

9 “(III) Title XXI of the Social Se-  
10 curity Act.

11 “(IV) Chapter 55 of title 10.

12 “(V) Chapter 89 of title 5.

13 “(VI) A State health benefits  
14 risk pool.

15 “(B) LOSS OF COVERAGE DEFINED.—For  
16 purposes of this paragraph, loss of coverage  
17 shall not include any of the following:

18 “(i) Voluntary termination of coverage  
19 by an individual, except if such termination  
20 is the result of circumstances described in  
21 clause (iii)(IV).

22 “(ii) Termination of coverage by the  
23 issuer or the plan sponsor of the coverage  
24 for any reason described in paragraph (1)  
25 or (2) of section 2742(b).

1           “(iii) Loss of any coverage that con-  
2           sists solely of coverage of excepted benefits  
3           (as defined in section 2791).

4           “(C) SPECIAL ENROLLMENT PERIOD.—  
5           Any special enrollment period shall not be less  
6           than 60 days and shall begin on the date of the  
7           qualifying event.

8           “(6) STANDARD PREMIUM RATES.—With re-  
9           spect to the premium rate charged by a health insur-  
10          ance issuer for health insurance coverage offered in  
11          the individual market, such rate, with respect to the  
12          particular plan or coverage involved, shall not vary  
13          based on any of the following health status-related  
14          factors in relation to an eligible individual or de-  
15          pendent:

16               “(A) Health status.

17               “(B) Medical condition (including physical  
18               and mental illnesses).

19               “(C) Claims experience.

20               “(D) Receipt of health care.

21               “(E) Medical history.

22               “(F) Genetic information.

23               “(G) Evidence of insurability (including  
24               conditions arising out of acts of domestic vio-  
25               lence).

1 “(H) Disability.”;

2 (2) by amending subsection (b) to read as fol-  
3 lows:

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

5 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
6 individual’ means an individual who is eligible under  
7 applicable State law to purchase individual health in-  
8 surance coverage in the State.

9 “(2) DEPENDENT.—The term ‘dependent’  
10 means an individual who, under the terms of the  
11 coverage and applicable State law, qualifies to enroll  
12 in such coverage as a dependent of an individual de-  
13 scribed in paragraph (1).”;

14 (3) by striking subsection (c); and

15 (4) by redesignating subsection (d) and the first  
16 subsection (e) as subsections (c) and (d), respec-  
17 tively.

18 (b) CONFORMING AMENDMENT.—Section 2744 of the  
19 Public Health Service Act (42 U.S.C. 300gg–44), as re-  
20 stored and revived by section 2 of this Act, is repealed.

21 (c) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply with respect to health insurance  
23 coverage offered for plan years beginning after the date  
24 of the enactment of this Act.

1 **TITLE III—INTERSTATE MARKET**  
 2 **FOR HEALTH INSURANCE**

3 **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**  
 4 **HEALTH INSURANCE COVERAGE.**

5 (a) IN GENERAL.—Title XXVII of the Public Health  
 6 Service Act (42 U.S.C. 300gg et seq.), as restored by sec-  
 7 tion 2, is amended by adding at the end the following new  
 8 part:

9 **“PART D—COOPERATIVE GOVERNING OF**  
 10 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

11 **“SEC. 2795. DEFINITIONS.**

12 “In this part:

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



1 spect to such designated State, the issuer is deemed  
2 to be doing business in that State.

3 “(2) SECONDARY STATE.—The term ‘secondary  
4 State’ means, with respect to individual health insur-  
5 ance coverage offered by a health insurance issuer,  
6 any State that is not the primary State. In the case  
7 of a health insurance issuer that is selling a policy  
8 in, or to a resident of, a secondary State, the issuer  
9 is deemed to be doing business in that secondary  
10 State.

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

17 “(4) INDIVIDUAL HEALTH INSURANCE COV-  
18 ERAGE.—The term ‘individual health insurance cov-  
19 erage’ means health insurance coverage offered in  
20 the individual market, as defined in section  
21 2791(e)(1), but does not include excepted benefits  
22 described in section 2791(c).

23 “(5) APPLICABLE STATE AUTHORITY.—The  
24 term ‘applicable State authority’ means, with respect  
25 to a health insurance issuer in a State, the State in-

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

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

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

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

14 “(7) COVERED LAWS.—

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

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

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

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

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

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

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

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

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

4                   “(A) Knowingly misrepresenting to claim-  
5                   ants and insured individuals relevant facts or  
6                   policy provisions relating to coverage at issue.

7                   “(B) Failing to acknowledge with reason-  
8                   able promptness pertinent communications with  
9                   respect to claims arising under policies.

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

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

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

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

22                  “(G) A pattern or practice of compelling  
23                  insured individuals or their beneficiaries to in-  
24                  stitute suits to recover amounts due under its  
25                  policies by offering substantially less than the

1 amounts ultimately recovered in suits brought  
2 by them.

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

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

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

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

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

1           “(A) Presenting, causing to be presented  
2 or preparing with knowledge or belief that it  
3 will be presented to or by an insurer, a rein-  
4 surer, broker or its agent, false information as  
5 part of, in support of or concerning a fact ma-  
6 terial to one or more of the following:

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

10                   “(ii) The rating of an insurance policy  
11 or reinsurance contract.

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

15                   “(iv) Premiums paid on an insurance  
16 policy or reinsurance contract.

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

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

23                   “(vii) The financial condition of an in-  
24 surer or reinsurer.

1           “(viii) The formation, acquisition,  
2           merger, reconsolidation, dissolution or  
3           withdrawal from one or more lines of in-  
4           surance or reinsurance in all or part of a  
5           State by an insurer or reinsurer.

6           “(ix) The issuance of written evidence  
7           of insurance.

8           “(x) The reinstatement of an insur-  
9           ance policy.

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

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

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

1 **“SEC. 2796. APPLICATION OF LAW.**

2       “(a) IN GENERAL.—The covered laws of the primary  
3 State shall apply to individual health insurance coverage  
4 offered by a health insurance issuer in the primary State  
5 and in any secondary State, but only if the coverage and  
6 issuer comply with the conditions of this section with re-  
7 spect to the offering of coverage in any secondary State.

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

17               “(1) make unlawful, or regulate, directly or in-  
18 directly, the operation of the health insurance issuer  
19 operating in the secondary State, except that any  
20 secondary State may require such an issuer—

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



1           “(B) to register with and designate the  
2 State insurance commissioner as its agent solely  
3 for the purpose of receiving service of legal doc-  
4 uments or process;

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

10           “(i) the State insurance commissioner  
11 of the primary State has not done an ex-  
12 amination within the period recommended  
13 by the National Association of Insurance  
14 Commissioners; and

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

21           “(D) to comply with a lawful order  
22 issued—

23           “(i) in a delinquency proceeding com-  
24 menced by the State insurance commis-  
25 sioner if there has been a finding of finan-

1           cial impairment under subparagraph (C);

2           or

3           “(ii) in a voluntary dissolution pro-  
4           ceeding;

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

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

15          “(G) to comply with any State law regard-  
16          ing fraud and abuse (as defined in section  
17          2795(10)), except that if the State seeks an in-  
18          junction regarding the conduct described in this  
19          subparagraph, such injunction must be obtained  
20          from a court of competent jurisdiction;

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

24          “(I) to comply with the applicable require-  
25          ments for independent review under section

1           2799 with respect to coverage offered in the  
2           State;

3           “(2) require any individual health insurance  
4           coverage issued by the issuer to be countersigned by  
5           an insurance agent or broker residing in that sec-  
6           ondary State; or

7           “(3) otherwise discriminate against the issuer  
8           issuing insurance in both the primary State and in  
9           any secondary State.

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

20 This policy is issued by \_\_\_\_\_ and is governed by  
21 the laws and regulations of the State of \_\_\_\_\_, and  
22 it has met all the laws of that State as determined by  
23 that State’s Department of Insurance. This policy may be  
24 less expensive than others because it is not subject to all  
25 of the insurance laws and regulations of the State of

1 \_\_\_\_\_, including coverage of some services or bene-  
 2 fits mandated by the law of the State of \_\_\_\_\_. Ad-  
 3 ditionally, this policy is not subject to all of the consumer  
 4 protection laws or restrictions on rate changes of the State  
 5 of \_\_\_\_\_. As with all insurance products, before pur-  
 6 chasing this policy, you should carefully review the policy  
 7 and determine what health care services the policy covers  
 8 and what benefits it provides, including any exclusions,  
 9 limitations, or conditions for such services or benefits.

10       “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
 11 AND PREMIUM INCREASES.—

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

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

22               “(B) increase the premiums assessed the  
 23 individual for such coverage based on a health  
 24 status-related factor or change of a health sta-

1           tus-related factor or the past or prospective  
2           claim experience of the insured individual.

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

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

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

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

17                           “(i) are disclosed to the consumer in  
18                           the insurance contract;

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

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

24                  “(D) from reinstating lapsed coverage; or

1           “(E) from retroactively adjusting the rates  
2           charged an insured individual if the initial rates  
3           were set based on material misrepresentation by  
4           the individual at the time of issue.

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

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

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

24           “(1) to the insurance commissioner of each  
25           State in which it intends to offer such coverage, be-

1 fore it may offer individual health insurance cov-  
2 erage in such State—

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

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

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

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

21 “(A) a member of the American Academy  
22 of Actuaries; or

23 “(B) a qualified loss reserve specialist.

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

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

8               “(2) the solicitation or sale of individual health  
9 insurance coverage that violates the requirements of  
10 the law of a secondary State which are described in  
11 subparagraphs (A) through (H) of section  
12 2796(b)(1).

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

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

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



1           “(2) COURTS OF COMPETENT JURISDICTION.—

2           If a State seeks an injunction regarding the conduct  
3           described in paragraphs (1) and (2) of subsection  
4           (h), such injunction must be obtained from a Fed-  
5           eral or State court of competent jurisdiction.

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

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

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

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

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

10 **“SEC. 2798. LIMITATION ON INDIVIDUAL PURCHASE IN SEC-**  
11 **ONDARY STATE.**

12 “Effective beginning 2 years after the date of enact-  
13 ment of this part, an individual in a State may not buy  
14 individual health insurance coverage in a secondary State  
15 if the premium for individual health insurance in the pri-  
16 mary State (with respect to the individual) exceeds the  
17 national average premium by 10 percent or more.

18 **“SEC. 2799. INDEPENDENT EXTERNAL APPEALS PROCE-**  
19 **DURES.**

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

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

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

3 “(2) in any case in which the requirements of  
4 paragraph (1) are not met with respect to the either  
5 of such States, the issuer provides an independent  
6 review mechanism substantially identical (as deter-  
7 mined by the applicable State authority of such  
8 State) to that prescribed in the ‘Health Carrier Ex-  
9 ternal Review Model Act’ of the National Association  
10 of Insurance Commissioners for all individuals who  
11 purchase insurance coverage under the terms of this  
12 part, except that, under such mechanism, the review  
13 is conducted by an independent medical reviewer, or  
14 a panel of such reviewers, with respect to whom the  
15 requirements of subsection (b) are met.

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

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

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

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

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

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

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

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

19           “(3) INDEPENDENCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

17       **“SEC. 2799A. ENFORCEMENT.**

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

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

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

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

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

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

17 (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

17          (d) SEVERABILITY.—If any provision of the section  
18          or the application of such provision to any person or cir-  
19          cumstance is held to be unconstitutional, the remainder  
20          of this section and the application of the provisions of such  
21          to any other person or circumstance shall not be affected.

1           **TITLE IV—LAWSUIT ABUSE**  
2                           **REFORMS**

3   **SEC. 401. CHANGE IN BURDEN OF PROOF BASED ON COM-**  
4                           **PLIANCE WITH CLINICAL PRACTICE GUIDE-**  
5                           **LINES.**

6           (a) SELECTION AND ISSUANCE OF CLINICAL PRAC-  
7   TICES GUIDELINES.—

8                   (1) IN GENERAL.—The Secretary of Health and  
9           Human Services (in this section referred to as the  
10          “Secretary”) shall provide for the selection and  
11          issuance of clinical practice guidelines for treatment  
12          of medical conditions (each in this subsection re-  
13          ferred to as a “guideline”) in accordance with para-  
14          graphs (2) and (3).

15                   (2) DEVELOPMENT PROCESS.—Not later than  
16          90 days after the date of enactment of this title, the  
17          Secretary shall enter into a contract with a qualified  
18          physician consensus-building organization (such as  
19          the Physician Consortium for Performance Improve-  
20          ment), in concert and agreement with physician spe-  
21          cialty organizations, to develop guidelines. The con-  
22          tract shall require that the organization submit  
23          guidelines to the agency not later than 18 months  
24          after the date of the enactment of this title.

25                   (3) ISSUANCE.—

1 (A) IN GENERAL.—Not later than 2 years  
2 after the date of the enactment of this title, the  
3 Secretary shall, after notice and opportunity for  
4 public comment, make a rule that provides for  
5 the issuance of the guidelines submitted under  
6 paragraph (2).

7 (B) LIMITATION.—The Secretary may not  
8 make a rule that includes guidelines other than  
9 those submitted under paragraph (2).

10 (C) DISSEMINATION.—The Secretary shall  
11 post such guidelines on the public Internet Web  
12 site of the Department of Health and Human  
13 Services.

14 (4) MAINTENANCE.—Not later than 4 years  
15 after the date of enactment of this title, and every  
16 2 years thereafter, the Secretary shall review the  
17 guidelines and shall, as necessary, enter into con-  
18 tracts similar to the contract described in paragraph  
19 (2), and issue guidelines in a manner similar to the  
20 issuance of guidelines under paragraph (3).

21 (b) USE.—

22 (1) USE BY DEFENDANT TO CHANGE THE BUR-  
23 DEN OF PROOF.—If a defendant in a health care  
24 lawsuit relating to treatment of an individual estab-  
25 lishes by a preponderance of the evidence that the

1 treatment was provided in a manner consistent with  
2 an applicable guideline issued under subsection (a),  
3 the defendant may not be held liable unless the  
4 plaintiff establishes the liability of the defendant by  
5 clear and convincing evidence.

6 (2) LIMITATION ON INTRODUCTION AS EVIDENCE AGAINST A DEFENDANT.—Guidelines issued  
7 under subsection (a) may not be introduced as evidence  
8 of negligence or deviation in the standard of  
9 care in any health care lawsuit unless they have previously  
10 been introduced by the defendant.

12 (3) NO PRESUMPTION OF NEGLIGENCE AGAINST  
13 A DEFENDANT.—There shall be no presumption of  
14 negligence with respect to treatment if a health care  
15 provider provides the treatment in a manner inconsistent  
16 with such guidelines.

17 (c) CONSTRUCTION.—Nothing in this section shall be  
18 construed as preventing a State from—

19 (1) replacing their current medical malpractice  
20 rules with rules that rely, as a defense, upon a  
21 health care provider's compliance with a guideline  
22 issued under subsection (a); or

23 (2) applying additional guidelines or limitations  
24 on liability that are in addition to, but not in lieu  
25 of, the guidelines issued under subsection (a).

1 **SEC. 402. STATE GRANTS TO CREATE EXPERT PANELS AND**  
2 **ADMINISTRATIVE HEALTH CARE TRIBUNALS.**

3 Part P of title III of the Public Health Service Act  
4 (42 U.S.C. 280g et seq.) is amended by adding at the end  
5 the following:

6 **“SEC. 399U. STATE GRANTS TO CREATE ADMINISTRATIVE**  
7 **HEALTH CARE TRIBUNALS.**

8 “(a) IN GENERAL.—The Secretary may award grants  
9 to States for the development, implementation, and eval-  
10 uation of administrative health care tribunals that comply  
11 with this section, for the resolution of disputes concerning  
12 injuries allegedly caused by health care providers.

13 “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—  
14 To be eligible to receive a grant under this section, a State  
15 shall submit to the Secretary an application at such time,  
16 in such manner, and containing such information as may  
17 be required by the Secretary. A grant shall be awarded  
18 under this section on such terms and conditions as the  
19 Secretary determines appropriate.

20 “(c) REPRESENTATION BY COUNSEL.—A State that  
21 receives a grant under this section may not preclude any  
22 party to a dispute before an administrative health care tri-  
23 bunal operated under such grant from obtaining legal rep-  
24 resentation during any review by the expert panel under  
25 subsection (d), the administrative health care tribunal

1 under subsection (e), or a State court under subsection  
2 (f).

3 “(d) EXPERT PANEL REVIEW AND EARLY OFFER  
4 GUIDELINES.—

5 “(1) IN GENERAL.—If, in any health care liabil-  
6 ity action against a health care provider, the health  
7 care provider alleges, in any response to the claim-  
8 ant’s filing, that the health care provider adhered to  
9 an applicable practice guideline in the provision of  
10 health care items or services to the claimant, then  
11 further proceedings on the health care liability ac-  
12 tion shall be suspended prior to discovery pro-  
13 ceedings, until the completion of a review of the ac-  
14 tion by an independent expert panel in accordance  
15 with this subsection.

16 “(2) COMPOSITION.—

17 “(A) IN GENERAL.—The members of each  
18 expert panel under this subsection shall be ap-  
19 pointed by the head of the State agency respon-  
20 sible for health. Each expert panel shall be  
21 composed of no fewer than 3 members and not  
22 more than 5 members. At least one-half of such  
23 members shall be medical experts (either physi-  
24 cians or health care professionals).



1           “(B) LICENSURE AND EXPERTISE.—Each  
2 physician or health care professional appointed  
3 to an expert panel under subparagraph (A)  
4 shall—

5           “(i) be appropriately credentialed or  
6 licensed in one or more States to deliver  
7 health care services; and

8           “(ii) typically treat the condition,  
9 make the diagnosis, or provide the type of  
10 treatment that is under review.

11           “(C) INDEPENDENCE.—

12           “(i) IN GENERAL.—Subject to clause  
13 (ii), each individual appointed to an expert  
14 panel under this paragraph shall—

15           “(I) not have a material familial,  
16 financial, or professional relationship  
17 with a party involved in the dispute  
18 reviewed by the panel; and

19           “(II) not otherwise have a con-  
20 flict of interest with such a party.

21           “(ii) EXCEPTION.—Nothing in clause  
22 (i) shall be construed to prohibit an indi-  
23 vidual who has staff privileges at an insti-  
24 tution where the treatment involved in the  
25 dispute was provided from serving as a

1 member of an expert panel merely on the  
2 basis of such affiliation, if the affiliation is  
3 disclosed to the parties and neither party  
4 objects.

5 “(D) PRACTICING HEALTH CARE PROFES-  
6 SIONAL IN SAME FIELD.—

7 “(i) IN GENERAL.—In a dispute be-  
8 fore an expert panel that involves treat-  
9 ment, or the provision of items or serv-  
10 ices—

11 “(I) by a physician, the medical  
12 experts on the expert panel shall be  
13 practicing physicians (allopathic or os-  
14 teopathic) of the same or similar spe-  
15 cialty as a physician who typically  
16 treats the condition, makes the diag-  
17 nosis, or provides the type of treat-  
18 ment under review; or

19 “(II) by a health care profes-  
20 sional other than a physician, at least  
21 2 medical experts on the expert panel  
22 shall be practicing physicians  
23 (allopathic or osteopathic) of the same  
24 or similar specialty as the health care  
25 professional who typically treats the

1 condition, makes the diagnosis, or  
2 provides the type of treatment under  
3 review, and, if determined appropriate  
4 by the State agency, an additional  
5 medical expert shall be a practicing  
6 health care professional (other than  
7 such a physician) of such a same or  
8 similar specialty.

9 “(ii) PRACTICING DEFINED.—In this  
10 paragraph, the term ‘practicing’ means,  
11 with respect to an individual who is a phy-  
12 sician or other health care professional,  
13 that the individual provides health care  
14 services to individual patients on average  
15 at least 2 days a week.

16 “(E) PEDIATRIC EXPERTISE.—In the case  
17 of dispute relating to a child, at least 1 medical  
18 expert on the expert panel shall have expertise  
19 described in subparagraph (D)(i) in pediatrics.

20 “(F) NO CIVIL LIABILITY FOR MEM-  
21 BERS.—No civil action shall be brought in any  
22 court against any member of an expert panel  
23 for any act done, failure to act, or statement or  
24 opinion made, within the scope of the individ-  
25 ual’s duties as a member of the expert panel.

1 “(3) DETERMINATION.—

2 “(A) IN GENERAL.—After a review under  
3 paragraph (1), an expert panel shall make a de-  
4 termination as to the liability of the parties in-  
5 volved and compensation.

6 “(B) CONSIDERATIONS IN MAKING DETER-  
7 MINATIONS.—In making a determination under  
8 this subsection as to the liability of parties in-  
9 volved and compensation, the following shall  
10 apply:

11 “(i) TREATMENT OF CLINICAL PRAC-  
12 TICE GUIDELINES.—An expert panel shall  
13 acknowledge the ability of physicians to de-  
14 part from the recommendations in clinical  
15 practice guidelines, when appropriate, in  
16 the care of individual patients.

17 “(ii) LIMITATION.—An expert panel  
18 shall not make a finding of negligence  
19 from the mere fact that a treatment or  
20 procedure was unsuccessful or failed to  
21 bring the best result.

22 “(4) EARLY OFFER.—If the parties to a dispute  
23 before an expert panel under this subsection accept  
24 the determination of the expert panel concerning li-  
25 ability and compensation, such compensation shall

1 be paid to the claimant and the claimant shall agree  
2 to forgo any further action against the health care  
3 providers involved.

4 “(5) FAILURE TO ACCEPT.—If any party de-  
5 cides not to accept the expert panel’s determination,  
6 the matter shall be referred to an administrative  
7 health care tribunal created pursuant to this section.

8 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

9 “(1) IN GENERAL.—Upon the failure of any  
10 party to accept the determination of an expert panel  
11 under subsection (d), the parties shall have the right  
12 to request a hearing concerning the liability or com-  
13 pensation involved by an administrative health care  
14 tribunal established by the State involved.

15 “(2) REQUIREMENTS.—In establishing an ad-  
16 ministrative health care tribunal under this section,  
17 a State shall—

18 “(A) ensure that such tribunals are pre-  
19 sided over by special judges with health care ex-  
20 pertise;

21 “(B) provide authority to such judges to  
22 make binding rulings, rendered in written deci-  
23 sions, on standards of care, causation, com-  
24 pensation, and related issues with reliance on

1 independent expert witnesses commissioned by  
2 the tribunal;

3 “(C) establish gross negligence as the legal  
4 standard for the tribunal; and

5 “(D) allow the admission into evidence of  
6 the recommendation made by the expert panel  
7 under subsection (d).

8 “(f) REVIEW BY STATE COURT AFTER EXHAUSTION  
9 OF ADMINISTRATIVE REMEDIES.—

10 “(1) RIGHT TO FILE.—If any party to a dispute  
11 before a health care tribunal under subsection (e) is  
12 not satisfied with the determinations of the tribunal,  
13 the party shall have the right to file their claim in  
14 a State court of competent jurisdiction.

15 “(2) FORFEIT OF AWARDS.—Any party filing  
16 an action in a State court in accordance with para-  
17 graph (1) shall forfeit any compensation award  
18 made under subsection (e).

19 “(3) ADMISSIBILITY.—The determinations of  
20 the expert panel and the administrative health care  
21 tribunal pursuant to subsections (d) and (e) with re-  
22 spect to a State court proceeding under paragraph  
23 (1) shall be admissible into evidence in any such  
24 State court proceeding.

1           “(4) TREATMENT OF CERTAIN EXPERT PANEL  
2           AND ADMINISTRATIVE HEALTH CARE TRIBUNAL  
3           FINDINGS.—

4           “(A) WORK PRODUCT.—No finding by an  
5           expert panel under subsection (d) or adminis-  
6           trative health care tribunal under subsection (e)  
7           that the defendant applicable eligible profes-  
8           sional breached the standard of care as set  
9           forth under the prescribed practice guidelines  
10          shall constitute negligence per se or conclusive  
11          evidence of liability.

12          “(B) FINDING RELATING TO CLINICAL  
13          PRACTICE GUIDELINES.—If an administrative  
14          health care tribunal did not make a finding  
15          under subsection (e) that there was an applica-  
16          ble clinical practice guideline that the defendant  
17          adhered to, with respect to the State court pro-  
18          ceeding under paragraph (1) the State court  
19          may issue summary judgment in favor of the  
20          defendant health care professional unless the  
21          claimant is able to show otherwise by clear and  
22          convincing evidence. If an administrative health  
23          care tribunal made a finding under subsection  
24          (e) that there was an applicable clinical practice  
25          guideline that the defendant adhered to, with

1           respect to a State court proceeding under para-  
2           graph (1) the State court shall issue summary  
3           judgment in favor of the applicable health care  
4           professional unless the claimant is able to show  
5           otherwise by clear and convincing evidence.

6           “(C) FINDING RELATING TO STANDARD OF  
7           CARE.—Any finding of an expert panel or ad-  
8           ministrative health care tribunal under sub-  
9           section (d) or (e), respectively, that the defend-  
10          ant did not breach the standard of care as set  
11          forth under the prescribed clinical practice  
12          guidelines or that the defendant’s failure to  
13          conform to the required standard was neither  
14          the cause in fact nor the proximate cause of the  
15          plaintiff’s injury or that the plaintiff did not  
16          incur any damages as a result shall be given  
17          deference by the State court involved and shall  
18          entitle the defendant to summary judgment un-  
19          less the plaintiff is able to show by clear and  
20          convincing evidence that the expert panel or  
21          health care tribunal, respectively, was in error  
22          and that there is a genuine issue as to a mate-  
23          rial fact in the case.

24          “(g) DEFINITION.—In this section, the term ‘health  
25          care provider’ means any person or entity required by



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

5 “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
 6 are authorized to be appropriated for any fiscal year such  
 7 sums as may be necessary for purposes of making grants  
 8 to States under this section.”.

9 **SEC. 403. PAYMENT OF DAMAGES AND RECOVERY OF**  
 10 **COSTS IN HEALTH CARE LAWSUITS.**

11 (a) AUTHORIZATION OF PAYMENT OF FUTURE DAM-  
 12 AGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.—In  
 13 any health care lawsuit, if an award of future damages,  
 14 without reduction to present value, equaling or exceeding  
 15 \$50,000 is made against a party with sufficient insurance  
 16 or other assets to fund a periodic payment of such a judg-  
 17 ment, the court shall, at the request of any party, enter  
 18 a judgment ordering that the future damages be paid by  
 19 periodic payments, in accordance with the Uniform Peri-  
 20 odic Payment of Judgments Act promulgated by the Na-  
 21 tional Conference of Commissioners on Uniform State  
 22 Laws.

23 (b) RECOVERY OF COSTS; PAYMENT OF AWARD.—  
 24 In any health care lawsuit, the court may supervise the  
 25 arrangements for payment of damages to protect against

1 conflicts of interest that may have the effect of reducing  
2 the amount of damages awarded that are actually paid  
3 to claimants. In particular, in any health care lawsuit in  
4 which the attorney for a party claims a financial stake  
5 in the outcome by virtue of a contingent fee, the court  
6 shall have the power to restrict the payment of a claim-  
7 ant's damage recovery to such attorney, and to redirect  
8 such damages to the claimant based upon the interests  
9 of justice and principles of equity.

10 (c) APPLICABILITY.—This section applies to all ac-  
11 tions which have not been first set for trial or retrial be-  
12 fore the effective date of this title.

13 (d) STATUTE OF LIMITATIONS.—

14 (1) IN GENERAL.—Except in the case of a  
15 State law that provides for a shorter period of time,  
16 the time for the commencement of a health care law-  
17 suit shall be no more than 3 years after the date of  
18 manifestation of injury or 1 year after the claimant  
19 discovers, or through the use of reasonable diligence  
20 should have discovered, the injury, whichever occurs  
21 first. In no event shall the time for commencement  
22 of a health care lawsuit exceed 3 years after the date  
23 of manifestation of injury unless tolled for any of  
24 the following—

25 (A) upon proof of fraud;

1 (B) intentional concealment; or

2 (C) the presence of a foreign body, which  
3 has no therapeutic or diagnostic purpose or ef-  
4 fect, in the person of the injured person.

5 (2) CASES INVOLVING MINORS.—Except in the  
6 case of a State law that provides for a shorter period  
7 of time, actions by a minor shall be commenced  
8 within 3 years from the date of the alleged mani-  
9 festation of injury except that actions by a minor  
10 under the full age of 6 years shall be commenced  
11 within 3 years of manifestation of injury or prior to  
12 the minor's 8th birthday, whichever provides a  
13 longer period. Such time limitation shall be tolled for  
14 minors for any period during which a parent or  
15 guardian and a health care provider or health care  
16 organization have committed fraud or collusion in  
17 the failure to bring an action on behalf of the in-  
18 jured minor.

19 (e) FAIR SHARE RULE.—In any health care lawsuit,  
20 each party shall be liable for that party's several share  
21 of any damages only and not for the share of any other  
22 person. Each party shall be liable only for the amount of  
23 damages allocated to such party in direct proportion to  
24 such party's percentage of responsibility. Whenever a  
25 judgment of liability is rendered as to any party, a sepa-

1 rate judgment shall be rendered against each such party  
 2 for the amount allocated to such party. For purposes of  
 3 this section, the trier of fact shall determine the propor-  
 4 tion of responsibility of each party for the claimant's  
 5 harm.

6 (f) APOLOGIES.—In any health care lawsuit, if a  
 7 claimant receives any expression of regret for any act per-  
 8 taining to conduct giving rise to the health care lawsuit,  
 9 such expression of regret, notwithstanding any applicable  
 10 rule of evidence may not be admitted into evidence in the  
 11 health care lawsuit.

12 **SEC. 404. DEFINITIONS.**

13 In this title:

14 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
 15 TEM; ADR.—The term “alternative dispute resolution  
 16 system” or “ADR” means a system that provides  
 17 for the resolution of health care lawsuits in a man-  
 18 ner other than through a civil action brought in a  
 19 State or Federal court.

20 (2) CLAIMANT.—The term “claimant” means  
 21 any person who brings a health care lawsuit, includ-  
 22 ing a person who asserts or claims a right to legal  
 23 or equitable contribution, indemnity, or subrogation,  
 24 arising out of a health care liability claim or action,  
 25 and any person on whose behalf such a claim is as-

1       serted or such an action is brought, whether de-  
2       ceased, incompetent, or a minor.

3               (3) FEDERAL TAX BENEFIT.—A claimant shall  
4       be treated as receiving a Federal tax benefit with re-  
5       spect to payment for items or services if—

6               (A) such payment is compensation by in-  
7       surance—

8                       (i) which constitutes medical care, and

9                       (ii) with respect to the payment of  
10       premiums for which the claimant, or the  
11       employer of the claimant, was allowed an  
12       exclusion from gross income, a deduction,  
13       or a credit for Federal income tax pur-  
14       poses,

15               (B) a deduction was allowed with respect  
16       to such payment for Federal income tax pur-  
17       poses, or

18               (C) such payment was from an Archer  
19       MSA (as defined in section 220(d) of the Inter-  
20       nal Revenue Code of 1986), a health savings  
21       account (as defined in section 223(d) of such  
22       Code), a flexible spending arrangement (as de-  
23       fined in section 106(e)(2) of such Code), or a  
24       health reimbursement arrangement which is  
25       treated as employer-provided coverage under an

1           accident or health plan for purposes of section  
2           106 of such Code.

3           (4) HEALTH CARE LAWSUIT.—The term  
4           “health care lawsuit” means any health care liability  
5           claim concerning the provision of health care goods  
6           or services brought in a Federal court or in a State  
7           court or pursuant to an alternative dispute resolu-  
8           tion system, if such claim concerns items or services  
9           for which coverage is provided under title XVIII,  
10          XIX, or XXI of the Social Security Act or for which  
11          the claimant receives a Federal tax benefit, against  
12          a health care provider, a health care organization, or  
13          the manufacturer, distributor, supplier, marketer,  
14          promoter, or seller of a medical product, regardless  
15          of the theory of liability on which the claim is based,  
16          or the number of claimants, plaintiffs, defendants,  
17          or other parties, or the number of claims or causes  
18          of action, in which the claimant alleges a health care  
19          liability claim. Such term does not include a claim  
20          or action which is based on criminal liability; which  
21          seeks civil fines or penalties paid to Federal Govern-  
22          ment; or which is grounded in antitrust.

23          (5) HEALTH CARE LIABILITY ACTION.—The  
24          term “health care liability action” means a civil ac-  
25          tion brought in a State or Federal court or pursuant

1 to an alternative dispute resolution system, against  
2 a health care provider, a health care organization, or  
3 the manufacturer, distributor, supplier, marketer,  
4 promoter, or seller of a medical product, regardless  
5 of the theory of liability on which the claim is based,  
6 or the number of plaintiffs, defendants, or other par-  
7 ties, or the number of causes of action, in which the  
8 claimant alleges a health care liability claim.

9 (6) HEALTH CARE LIABILITY CLAIM.—The  
10 term “health care liability claim” means a demand  
11 by any person, whether or not pursuant to ADR,  
12 against a health care provider, health care organiza-  
13 tion, or the manufacturer, distributor, supplier, mar-  
14 keter, promoter, or seller of a medical product, in-  
15 cluding third-party claims, cross-claims, counter-  
16 claims, or contribution claims, which are based upon  
17 the provision of, use of, or payment for (or the fail-  
18 ure to provide, use, or pay for) health care services  
19 or medical products, regardless of the theory of li-  
20 ability on which the claim is based, or the number  
21 of plaintiffs, defendants, or other parties, or the  
22 number of causes of action.

23 (7) HEALTH CARE ORGANIZATION.—The term  
24 “health care organization” means any person or en-  
25 tity which is obligated to provide or pay for health

1 benefits under any health plan, including any person  
2 or entity acting under a contract or arrangement  
3 with a health care organization to provide or admin-  
4 ister any health benefit.

5 (8) HEALTH CARE PROVIDER.—The term  
6 “health care provider” means any person or entity  
7 required by State or Federal laws or regulations to  
8 be licensed, registered, or certified to provide health  
9 care services, and being either so licensed, reg-  
10 istered, or certified, or exempted from such require-  
11 ment by other statute or regulation.

12 (9) HEALTH CARE GOODS OR SERVICES.—The  
13 term “health care goods or services” means any  
14 goods or services provided by a health care organiza-  
15 tion, provider, or by any individual working under  
16 the supervision of a health care provider, that relates  
17 to the diagnosis, prevention, or treatment of any  
18 human disease or impairment, or the assessment or  
19 care of the health of human beings.

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



1 U.S.C. 321(g)(1) and (h)) and section 351(a) of the  
2 Public Health Service Act (42 U.S.C. 262(a)), re-  
3 spectively, including any component or raw material  
4 used therein, but excluding health care services.

5 (11) MEDICAL TREATMENT.—The term “med-  
6 ical treatment” means the provision of any goods or  
7 services by a health care provider or by any indi-  
8 vidual working under the supervision of a health  
9 care provider, that relates to the diagnosis, preven-  
10 tion, or treatment of any human disease or impair-  
11 ment, or the assessment or care of the health of  
12 human beings.

13 (12) RECOVERY.—The term “recovery” means  
14 the net sum recovered after deducting any disburse-  
15 ments or costs incurred in connection with prosecu-  
16 tion or settlement of the claim, including all costs  
17 paid or advanced by any person. Costs of health care  
18 incurred by the plaintiff and the attorneys’ office  
19 overhead costs or charges for legal services are not  
20 deductible disbursements or costs for such purpose.

21 (13) STATE.—The term “State” means each of  
22 the several States, the District of Columbia, the  
23 Commonwealth of Puerto Rico, the Virgin Islands,  
24 Guam, American Samoa, the Northern Mariana Is-  
25 lands, the Trust Territory of the Pacific Islands, and

1 any other territory or possession of the United  
2 States, or any political subdivision thereof.

3 **SEC. 405. EFFECT ON OTHER LAWS.**

4 (a) VACCINE INJURY.—

5 (1) NON-APPLICABILITY OF THIS TITLE.—To  
6 the extent that title XXI of the Public Health Serv-  
7 ice Act establishes a Federal rule of law applicable  
8 to a civil action brought for a vaccine-related injury  
9 or death—

10 (A) this title does not affect the application  
11 of the rule of law to such an action; and

12 (B) any rule of law prescribed by this title  
13 in conflict with a rule of law of such title XXI  
14 shall not apply to such action.

15 (2) APPLICABILITY OF THIS TITLE.—If there is  
16 an aspect of a civil action brought for a vaccine-re-  
17 lated injury or death to which a Federal rule of law  
18 under title XXI of the Public Health Service Act  
19 does not apply, then this title or otherwise applicable  
20 law (as determined under this title) will apply to  
21 such aspect of such action.

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

1 **SEC. 406. APPLICABILITY; EFFECTIVE DATE.**

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

10 **TITLE V—WELLNESS AND**  
11 **PREVENTION**

12 **SEC. 501. PROVIDING FINANCIAL INCENTIVES FOR TREAT-**  
13 **MENT COMPLIANCE.**

14 (a) LIMITATION ON EXCEPTION FOR WELLNESS  
15 PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

16 (1) EMPLOYEE RETIREMENT INCOME SECURITY  
17 ACT OF 1974 AMENDMENT.—Section 702(b)(2) of the  
18 Employee Retirement Income Security Act of 1974  
19 (29 U.S.C. 1182(b)(2)) is amended by adding after  
20 subparagraph (B) the following:

21 “In applying subparagraph (B), a group health plan  
22 (or a health insurance issuer with respect to health  
23 insurance coverage) may vary premiums and cost-  
24 sharing by up to 50 percent of the value of the bene-  
25 fits under the plan (or coverage) based on participa-

1       tion (or lack of participation) in a standards-based  
2       wellness program.”.

3           (2) PHSA AMENDMENT.—Section 2702(b)(2)  
4       of the Public Health Service Act (42 U.S.C. 300gg–  
5       1(b)(2)) is amended by adding after subparagraph  
6       (B) the following:

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

14          (3) IRC AMENDMENT.—Section 9802(b)(2) of  
15      the Internal Revenue Code of 1986 is amended by  
16      adding after subparagraph (B) the following:

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

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

1 **TITLE VI—TRANSPARENCY AND**  
2 **INSURANCE REFORM MEASURES**

3 **SEC. 601. RECEIPT AND RESPONSE TO REQUESTS FOR**  
4 **CLAIM INFORMATION.**

5 (a) IN GENERAL.—Title XXVII of the Public Health  
6 Service Act is amended by inserting after section 2713 the  
7 following new section:

8 **“SEC. 2714. RECEIPT AND RESPONSE TO REQUESTS FOR**  
9 **CLAIM INFORMATION.**

10 “(a) REQUIREMENT.—

11 “(1) IN GENERAL.—In the case of health insur-  
12 ance coverage offered in connection with a group  
13 health plan, not later than 30 days after the date on  
14 which a health insurance issuer receives a written  
15 request for a written report of claim information  
16 from the plan, plan sponsor, or plan administrator,  
17 the health insurance issuer shall provide the request-  
18 ing party the report, subject to the succeeding provi-  
19 sions of this section.

20 “(2) EXCEPTION.—The health insurance issuer  
21 is not obligated to provide a report under this sub-  
22 section regarding a particular employer or group  
23 health plan more than twice in any 12-month period  
24 and is not obligated to provide such a report in the  
25 case of an employer with fewer than 50 employees.

1           “(3) DEADLINE.—A plan, plan sponsor, or plan  
2 administrator must request a report under this sub-  
3 section before or on the second anniversary of the  
4 date of termination of coverage under a group health  
5 plan issued by the health insurance issuer.

6           “(b) FORM OF REPORT; INFORMATION TO BE IN-  
7 CLUDED.—

8           “(1) IN GENERAL.—A health insurance issuer  
9 shall provide the report of claim information under  
10 subsection (a)—

11                   “(A) in a written report;

12                   “(B) through an electronic file transmitted  
13 by secure electronic mail or a file transfer pro-  
14 tocol site; or

15                   “(C) by making the required information  
16 available through a secure Internet Web site or  
17 Web portal accessible by the requesting plan,  
18 plan sponsor, or plan administrator.

19           “(2) INFORMATION TO BE INCLUDED.—A re-  
20 port of claim information provided under subsection  
21 (a) shall contain all information available to the  
22 health insurance issuer that is responsive to the re-  
23 quest made under such subsection, including, subject  
24 to subsection (c), protected health information, for  
25 the 3-year period preceding the date of the report or

1 the period specified by subparagraphs (D), (E), and  
2 (F) of paragraph (3), if applicable, or for the entire  
3 period of coverage, whichever period is shorter.

4 “(3) REQUIRED INFORMATION.—Subject to  
5 subsection (c), a report provided under subsection  
6 (a) shall include the following:

7 “(A) Aggregate paid claims experience by  
8 month, including claims experience for medical,  
9 dental, and pharmacy benefits, as applicable.

10 “(B) Total premium paid by month.

11 “(C) Total number of covered employees  
12 on a monthly basis by coverage tier, including  
13 whether coverage was for—

14 “(i) an employee only;

15 “(ii) an employee with dependents  
16 only;

17 “(iii) an employee with a spouse only;

18 or

19 “(iv) an employee with a spouse and  
20 dependents.

21 “(D) The total dollar amount of claims  
22 pending as of the date of the report.

23 “(E) A separate description and individual  
24 claims report for any individual whose total  
25 paid claims exceed \$15,000 during the 12-

1 month period preceding the date of the report,  
2 including the following information related to  
3 the claims for that individual—

4 “(i) a unique identifying number,  
5 characteristic, or code for the individual;

6 “(ii) the amounts paid;

7 “(iii) dates of service; and

8 “(iv) applicable procedure codes and  
9 diagnosis codes.

10 “(F) For claims that are not part of the  
11 information described in a previous subpara-  
12 graph, a statement describing precertification  
13 requests for hospital stays of 5 days or longer  
14 that were made during the 30-day period pre-  
15 ceding the date of the report.

16 “(c) LIMITATIONS ON DISCLOSURE.—

17 “(1) IN GENERAL.—A health insurance issuer  
18 may not disclose protected health information in a  
19 report of claim information provided under this sec-  
20 tion if the health insurance issuer is prohibited from  
21 disclosing that information under another State or  
22 Federal law that imposes more stringent privacy re-  
23 strictions than those imposed under Federal law  
24 under the HIPAA privacy regulations. To withhold



1 information in accordance with this subsection, the  
2 health insurance issuer shall—

3 “(A) notify the plan, plan sponsor, or plan  
4 administrator requesting the report that infor-  
5 mation is being withheld; and

6 “(B) provide to the plan, plan sponsor, or  
7 plan administrator a list of categories of claim  
8 information that the health insurance issuer has  
9 determined are subject to the more stringent  
10 privacy restrictions under another State or Fed-  
11 eral law.

12 “(2) PROTECTION.—A plan sponsor is entitled  
13 to receive protected health information under sub-  
14 paragraphs (E) and (F) of subsection (b)(3) and  
15 subsection (d) only after an appropriately authorized  
16 representative of the plan sponsor makes to the  
17 health insurance issuer a certification substantially  
18 similar to the following certification: ‘I hereby certify  
19 that the plan documents comply with the require-  
20 ments of section 164.504(f)(2) of title 45, Code of  
21 Federal Regulations, and that the plan sponsor will  
22 safeguard and limit the use and disclosure of pro-  
23 tected health information that the plan sponsor may  
24 receive from the group health plan to perform the  
25 plan administration functions.’.

1           “(3) RESULTS.—A plan sponsor that does not  
2 provide the certification required by paragraph (2) is  
3 not entitled to receive the protected health informa-  
4 tion described by subparagraphs (E) and (F) of sub-  
5 section (b)(3) and subsection (d), but is entitled to  
6 receive a report of claim information that includes  
7 the information described in subparagraphs (A)  
8 through (D) of subsection (b)(3).

9           “(4) INFORMATION.—In the case of a request  
10 made under subsection (a) after the date of termi-  
11 nation of coverage, the report shall contain all infor-  
12 mation available to the health insurance issuer as of  
13 the date of the report that is responsive to the re-  
14 quest, including protected health information, and  
15 including the information described in subsection  
16 (b)(3), for the period described in subsection (b)(2)  
17 preceding the date of termination of coverage or for  
18 the entire policy period, whichever period is shorter.  
19 Notwithstanding this subsection, the report may not  
20 include the protected health information described in  
21 subparagraphs (E) and (F) of subsection (b)(3) un-  
22 less a certification has been provided in accordance  
23 with paragraph (2).

24           “(d) REQUEST FOR ADDITIONAL INFORMATION.—

1           “(1) REVIEW.—On receipt of the report re-  
2           quired by subsection (a), the plan, plan sponsor, or  
3           plan administrator may review the report and, not  
4           later than 10 days after the date on which the re-  
5           port is received, may make a written request to the  
6           health insurance issuer for additional information in  
7           accordance with this subsection for specified individ-  
8           uals.

9           “(2) REQUEST.—With respect to a request for  
10          additional information concerning specified individ-  
11          uals for whom claims information has been provided  
12          under subsection (b)(3)(E), the health insurance  
13          issuer shall provide additional information on the  
14          prognosis or recovery if available and, for individuals  
15          in active case management, the most recent case  
16          management information, including any future ex-  
17          pected costs and treatment plan, that relate to the  
18          claims for that individual.

19          “(3) RESPONSE.—The health insurance issuer  
20          must respond to the request for additional informa-  
21          tion under this subsection not later than 15 days  
22          after the date of such request unless the requesting  
23          plan, plan sponsor, or plan administrator agrees to  
24          a request for additional time.

1           “(4) LIMITATION.—The health insurance issuer  
2 is not required to produce the report described by  
3 this subsection unless a certification has been pro-  
4 vided in accordance with subsection (c)(2).

5           “(5) COMPLIANCE WITH SECTION DOES NOT  
6 CREATE LIABILITY.—A health insurance issuer that  
7 releases information, including protected health in-  
8 formation, in accordance with this subsection has  
9 not violated a standard of care and is not liable for  
10 civil damages resulting from, and is not subject to  
11 criminal prosecution for, releasing that information.

12          “(e) LIMITATION ON PREEMPTION.—Nothing in this  
13 section is meant to limit States from enacting additional  
14 laws in addition to the provisions of this section, but not  
15 in lieu of such provisions.

16          “(f) DEFINITIONS.—In this section:

17           “(1) The terms ‘employer’, ‘plan administrator’,  
18 and ‘plan sponsor’ have the meanings given such  
19 terms in section 3 of the Employee Retirement In-  
20 come Security Act of 1974.

21           “(2) The term ‘HIPAA privacy regulations’ has  
22 the meaning given such term in section 1180(b)(3)  
23 of the Social Security Act.



1 of the Social Security Act (42 U.S.C. 1320a–7b(f));  
2 and

3 (2) shall ensure that comparative effectiveness  
4 research and patient-centered outcomes research  
5 conducted or supported by the Federal Government  
6 accounts for factors contributing to differences in  
7 the treatment response and treatment preferences of  
8 patients, including patient-reported outcomes,  
9 genomics and personalized medicine, the unique  
10 needs of health disparity populations, and indirect  
11 patient benefits.

12 (b) CONSULTATION AND APPROVAL REQUIRED.—  
13 Nothing the Federal Coordinating Council for Compara-  
14 tive Effectiveness Research finds can be released in final  
15 form until after consultation with and approved by rel-  
16 evant physician specialty organizations.

17 (c) RULE OF CONSTRUCTION.—Nothing in this sec-  
18 tion shall be construed as affecting the authority of the  
19 Commissioner of Food and Drugs under the Federal  
20 Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.)  
21 or the Public Health Service Act (42 U.S.C. 201 et seq.).

22 **SEC. 702. ESTABLISHMENT OF PERFORMANCE-BASED**  
23 **QUALITY MEASURES.**

24 Not later than January 1, 2017, the Secretary of  
25 Health and Human Services shall submit to Congress a

1 proposal for a formalized process for the development of  
 2 performance-based quality measures that could be applied  
 3 to physicians' services under the Medicare program under  
 4 title XVIII of the Social Security Act (42 U.S.C. 1395  
 5 et seq.). Such proposal shall be in concert and agreement  
 6 with the Physician Consortium for Performance Improve-  
 7 ment and shall only utilize measures agreed upon by each  
 8 physician specialty organization.

9 **TITLE VIII—STATE**  
 10 **TRANSPARENCY PLAN PORTAL**

11 **SEC. 801. PROVIDING INFORMATION ON HEALTH COV-**  
 12 **ERAGE OPTIONS AND HEALTH CARE PRO-**  
 13 **VIDERS.**

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

19 (1) on health insurance plans that have been  
 20 certified to be available for purchase in that State;  
 21 and

22 (2) on price and quality information on health  
 23 care providers (including physicians, hospitals, and  
 24 other health care institutions).

25 (b) PROHIBITIONS.—

1           (1) DIRECT ENROLLMENT.—A plan portal may  
2 not directly enroll individuals in health insurance  
3 plans or under a State Medicaid plan under title  
4 XIX of the Social Security Act (42 U.S.C. 1396 et  
5 seq.) or a State child health plan under the State  
6 Children’s Health Insurance Program established  
7 under title XXI of the Social Security Act (42  
8 U.S.C. 1397aa et seq.).

9           (2) CONFLICTS OF INTEREST.—

10           (A) COMPANIES.—A health insurance  
11 issuer offering a health insurance plan through  
12 a plan portal may not—

13                   (i) be the private entity developing  
14 and maintaining a plan portal under this  
15 section; or

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

18           (B) INDIVIDUALS.—An individual em-  
19 ployed by a health insurance issuer offering a  
20 health insurance plan through a plan portal  
21 may not serve as a director or officer for—

22                   (i) the private entity developing and  
23 maintaining a plan portal under this sec-  
24 tion; or

25                   (ii) the plan portal.



1 (c) CONSTRUCTION.—Nothing in this section shall be  
 2 construed to prohibit health insurance brokers and agents  
 3 from—

4 (1) utilizing the plan portal for any purpose; or  
 5 (2) marketing or offering health insurance  
 6 products.

7 (d) STATE DEFINED.—In this section, the term  
 8 “State” has the meaning given such term for purposes of  
 9 title XIX of the Social Security Act (42 U.S.C. 1396 et  
 10 seq.).

11 (e) HEALTH INSURANCE PLANS.—For purposes of  
 12 this section, the term “health insurance plan” does not  
 13 include coverage of excepted benefits, as defined in section  
 14 2791(c) of the Public Health Service Act (42 U.S.C.  
 15 300gg–91(c)).

## 16 **TITLE IX—PATIENT FREEDOM** 17 **OF CHOICE**

### 18 **SEC. 901. GUARANTEEING FREEDOM OF CHOICE AND CON-** 19 **TRACTING FOR PATIENTS UNDER MEDICARE.**

20 (a) IN GENERAL.—Section 1802 of the Social Secu-  
 21 rity Act (42 U.S.C. 1395a) is amended to read as follows:

22 “FREEDOM OF CHOICE AND CONTRACTING BY PATIENT  
 23 GUARANTEED

24 “SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any  
 25 individual entitled to insurance benefits under this title  
 26 may obtain health services from any institution, agency,

1 or person qualified to participate under this title if such  
2 institution, agency, or person undertakes to provide that  
3 individual such services.

4 “(b) FREEDOM TO CONTRACT BY MEDICARE BENE-  
5 FICIARIES.—

6 “(1) IN GENERAL.—Subject to the provisions of  
7 this subsection, nothing in this title shall prohibit a  
8 Medicare beneficiary from entering into a contract  
9 with an eligible professional (whether or not the pro-  
10 fessional is a participating or non-participating phy-  
11 sician or practitioner) for any item or service cov-  
12 ered under this title.

13 “(2) SUBMISSION OF CLAIMS.—Any Medicare  
14 beneficiary that enters into a contract under this  
15 section with an eligible professional shall be per-  
16 mitted to submit a claim for payment under this  
17 title for services furnished by such professional, and  
18 such payment shall be made in the amount that  
19 would otherwise apply to such professional under  
20 this title except that where such professional is con-  
21 sidered to be non-participating, payment shall be  
22 paid as if the professional were participating. Pay-  
23 ment made under this title for any item or service  
24 provided under the contract shall not render the pro-  
25 fessional a participating or non-participating physi-

1       cian or practitioner, and as such, requirements of  
2       this title that may otherwise apply to a participating  
3       or non-participating physician or practitioner would  
4       not apply with respect to any items or services fur-  
5       nished under the contract.

6           “(3) BENEFICIARY PROTECTIONS.—

7           “(A) IN GENERAL.—Paragraph (1) shall  
8       not apply to any contract unless—

9           “(i) the contract is in writing, is  
10       signed by the Medicare beneficiary and the  
11       eligible professional, and establishes all  
12       terms of the contract (including specific  
13       payment for items and services covered by  
14       the contract) before any item or service is  
15       provided pursuant to the contract, and the  
16       beneficiary shall be held harmless for any  
17       subsequent payment charged for an item  
18       or service in excess of the amount estab-  
19       lished under the contract during the period  
20       the contract is in effect;

21          “(ii) the contract contains the items  
22       described in subparagraph (B); and

23          “(iii) the contract is not entered into  
24       at a time when the Medicare beneficiary is

1 facing an emergency medical condition or  
2 urgent health care situation.

3 “(B) ITEMS REQUIRED TO BE INCLUDED  
4 IN CONTRACT.—Any contract to provide items  
5 and services to which paragraph (1) applies  
6 shall clearly indicate to the Medicare beneficiary  
7 that by signing such contract the beneficiary—

8 “(i) agrees to be responsible for pay-  
9 ment to such eligible professional for such  
10 items or services under the terms of and  
11 amounts established under the contract;

12 “(ii) agrees to be responsible for sub-  
13 mitting claims under this title to the Sec-  
14 retary, and to any other supplemental in-  
15 surance plan that may provide supple-  
16 mental insurance, for such items or serv-  
17 ices furnished under the contract if such  
18 items or services are covered by this title,  
19 unless otherwise provided in the contract  
20 under subparagraph (C)(i); and

21 “(iii) acknowledges that no limits or  
22 other payment incentives that may other-  
23 wise apply under this title (such as the  
24 limits under subsection (g) of section 1848  
25 or incentives under subsections (a)(5), (m),

1 (q), and (p) of such section) shall apply to  
2 amounts that may be charged, or paid to  
3 a beneficiary for, such items or services.

4 Such contract shall also clearly indicate whether  
5 the eligible professional is excluded from par-  
6 ticipation under the Medicare program under  
7 section 1128.

8 “(C) BENEFICIARY ELECTIONS UNDER  
9 THE CONTRACT.—Any Medicare beneficiary  
10 that enters into a contract under this section  
11 may elect to negotiate, as a term of the con-  
12 tract, a provision under which—

13 “(i) the eligible professional shall file  
14 claims on behalf of the beneficiary with the  
15 Secretary and any supplemental insurance  
16 plan for items or services furnished under  
17 the contract if such items or services are  
18 covered under this title or under the plan;  
19 and

20 “(ii) the beneficiary assigns payment  
21 to the eligible professional for any claims  
22 filed by, or on behalf of, the beneficiary  
23 with the Secretary and any supplemental  
24 insurance plan for items or services fur-  
25 nished under the contract.

1           “(D) EXCLUSION OF DUAL ELIGIBLE INDI-  
2           VIDUALS.—Paragraph (1) shall not apply to  
3           any contract if a beneficiary who is eligible for  
4           medical assistance under title XIX is a party to  
5           the contract.

6           “(4) LIMITATION ON ACTUAL CHARGE AND  
7           CLAIM SUBMISSION REQUIREMENT NOT APPLICA-  
8           BLE.—Section 1848(g) shall not apply with respect  
9           to any item or service provided to a Medicare bene-  
10          ficiary under a contract described in paragraph (1).

11          “(5) CONSTRUCTION.—Nothing in this section  
12          shall be construed—

13                 “(A) to prohibit any eligible professional  
14                 from maintaining an election and acting as a  
15                 participating or non-participating physician or  
16                 practitioner with respect to any patient not cov-  
17                 ered under a contract established under this  
18                 section; and

19                 “(B) as changing the items and services  
20                 for which an eligible professional may bill under  
21                 this title.

22          “(6) DEFINITIONS.—In this subsection:

23                 “(A) MEDICARE BENEFICIARY.—The term  
24                 ‘Medicare beneficiary’ means an individual who

1 is entitled to benefits under part A or enrolled  
2 under part B.

3 “(B) ELIGIBLE PROFESSIONAL.—The term  
4 ‘eligible professional’ has the meaning given  
5 such term in section 1848(k)(3)(B).

6 “(C) EMERGENCY MEDICAL CONDITION.—  
7 The term ‘emergency medical condition’ means  
8 a medical condition manifesting itself by acute  
9 symptoms of sufficient severity (including se-  
10 vere pain) such that a prudent layperson, with  
11 an average knowledge of health and medicine,  
12 could reasonably expect the absence of imme-  
13 diate medical attention to result in—

14 “(i) serious jeopardy to the health of  
15 the individual or, in the case of a pregnant  
16 woman, the health of the woman or her  
17 unborn child;

18 “(ii) serious impairment to bodily  
19 functions; or

20 “(iii) serious dysfunction of any bodily  
21 organ or part.

22 “(D) URGENT HEALTH CARE SITUA-  
23 TION.—The term ‘urgent health care situation’  
24 means services furnished to an individual who  
25 requires services to be furnished within 12

1           hours in order to avoid the likely onset of an  
2           emergency medical condition.”.

3 **SEC. 902. PREEMPTION OF STATE LAWS LIMITING**  
4                   **CHARGES FOR ELIGIBLE PROFESSIONAL**  
5                   **SERVICES.**

6           (a) IN GENERAL.—No State may impose a limit on  
7 the amount of charges for services, furnished by an eligible  
8 professional (as defined in subsection (k)(3)(B) of section  
9 1848 of the Social Security Act, 42 U.S.C. 1395w-4), for  
10 which payment is made under such section, and any such  
11 limit is hereby preempted.

12           (b) STATE.—In this section, the term “State” in-  
13 cludes the District of Columbia, Puerto Rico, the Virgin  
14 Islands, Guam, and American Samoa.

15 **SEC. 903. HEALTH CARE PROVIDER LICENSURE CANNOT BE**  
16                   **CONDITIONED ON PARTICIPATION IN A**  
17                   **HEALTH PLAN.**

18           (a) IN GENERAL.—The Secretary of Health and  
19 Human Services and any State (as a condition of receiving  
20 Federal financial participation under title XIX of the So-  
21 cial Security Act) may not require any health care pro-  
22 vider to participate in any health plan as a condition of  
23 licensure of the provider in any State.

24           (b) DEFINITIONS.—In this section:



1           (1) HEALTH PLAN.—The term “health plan”  
2           has the meaning given such term in section 1171(5)  
3           of the Social Security Act (42 U.S.C. 1320d(5)).

4           (2) HEALTH CARE PROVIDER.—The term  
5           “health care provider” means any person or entity  
6           that is required by State or Federal laws or regula-  
7           tions to be licensed, registered, or certified to pro-  
8           vide health care services and is so licensed, reg-  
9           istered, or certified, or exempted from such require-  
10          ment by other statute or regulation.

11          (3) STATE.—The term “State” has the mean-  
12          ing given such term for purposes of title XIX of the  
13          Social Security Act.

14 **SEC. 904. BAD DEBT DEDUCTION FOR DOCTORS TO PAR-**  
15 **TIALLY OFFSET THE COST OF PROVIDING UN-**  
16 **COMPENSATED CARE REQUIRED TO BE PRO-**  
17 **VIDED UNDER AMENDMENTS MADE BY THE**  
18 **EMERGENCY MEDICAL TREATMENT AND**  
19 **LABOR ACT.**

20          (a) IN GENERAL.—Section 166 of the Internal Rev-  
21          enue Code of 1986 (relating to bad debts) is amended by  
22          redesignating subsection (f) as subsection (g) and by in-  
23          serting after subsection (e) the following new subsection:

1       “(f) BAD DEBT TREATMENT FOR DOCTORS TO PAR-  
2 Tially OFFSET COST OF PROVIDING UNCOMPENSATED  
3 CARE REQUIRED TO BE PROVIDED.—

4           “(1) AMOUNT OF DEDUCTION.—

5               “(A) IN GENERAL.—For purposes of sub-  
6 section (a), the basis for determining the  
7 amount of any deduction for an eligible  
8 EMTALA debt shall be treated as being equal  
9 to the Medicare payment amount.

10              “(B) MEDICARE PAYMENT AMOUNT.—For  
11 purposes of subparagraph (A), the Medicare  
12 payment amount with respect to an eligible  
13 EMTALA debt is the fee schedule amount es-  
14 tablished under section 1848 of the Social Secu-  
15 rity Act for the physicians’ service (to which  
16 such debt relates) as if the service were pro-  
17 vided to an individual enrolled under part B of  
18 title XVIII of such Act.

19              “(2) ELIGIBLE EMTALA DEBT.—For purposes  
20 of this section, the term ‘eligible EMTALA debt’  
21 means any debt if—

22                   “(A) such debt arose as a result of physi-  
23 cians’ services—

24                           “(i) which were performed in an  
25 EMTALA hospital by a board-certified

1 physician (whether as part of medical  
2 screening or necessary stabilizing treat-  
3 ment and whether as an emergency depart-  
4 ment physician, as an on-call physician, or  
5 otherwise), and

6 “(ii) which were required to be pro-  
7 vided under section 1867 of the Social Se-  
8 curity Act (42 U.S.C. 1395dd), and

9 “(B) such debt is owed—

10 “(i) to such physician, or

11 “(ii) to an entity if—

12 “(I) such entity is a corporation  
13 and the sole shareholder of such cor-  
14 poration is such physician, or

15 “(II) such entity is a partnership  
16 and any deduction under this sub-  
17 section with respect to such debt is al-  
18 located to such physician or to an en-  
19 tity described in subclause (I).

20 “(3) BOARD-CERTIFIED PHYSICIAN.—For pur-  
21 poses of this subsection, the term ‘board-certified  
22 physician’ means any physician (as defined in sec-  
23 tion 1861(r) of the Social Security Act (42 U.S.C.  
24 1395x(r))) who is certified by the American Board  
25 of Emergency Medicine or other appropriate medical

1 specialty board for the specialty in which the physi-  
2 cian practices, or who meets comparable require-  
3 ments, as identified by the Secretary of the Treasury  
4 in consultation with Secretary of Health and Human  
5 Services.

6 “(4) OTHER DEFINITIONS.—For purposes of  
7 this subsection—

8 “(A) EMTALA HOSPITAL.—The term  
9 ‘EMTALA hospital’ means any hospital having  
10 a hospital emergency department which is re-  
11 quired to comply with section 1867 of the So-  
12 cial Security Act (42 U.S.C. 1395dd) (relating  
13 to examination and treatment for emergency  
14 medical conditions and women in labor).

15 “(B) PHYSICIANS’ SERVICES.—The term  
16 ‘physicians’ services’ has the meaning given  
17 such term in section 1861(q) of the Social Se-  
18 curity Act (42 U.S.C. 1395x(q)).”.

19 (b) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to debts arising from services per-  
21 formed in taxable years beginning after the date of the  
22 enactment of this Act.

1 **SEC. 905. RIGHT OF CONTRACT WITH HEALTH CARE PRO-**  
2 **VIDERS.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services shall not preclude an enrollee, partici-  
5 pant, or beneficiary in a health benefits plan from entering  
6 into any contract or arrangement for health care with any  
7 health care provider.

8 (b) HEALTH BENEFITS PLAN DEFINED.—

9 (1) IN GENERAL.—In this section, subject to  
10 paragraph (2), the term “health benefits plan”  
11 means any of the following:

12 (A) A group health plan (as defined in sec-  
13 tion 2791 of the Public Health Service Act (42  
14 U.S.C. 300g–1)).

15 (B) Health insurance coverage (as defined  
16 in section 2791 of such Act (42 U.S.C. 300g–  
17 1)).

18 (C) A health benefits plan under chapter  
19 89 of title 5, United States Code.

20 (2) EXCLUSION OF MEDICAID AND TRICARE.—  
21 Such term does not include a health plan partici-  
22 pating in—

23 (A) the Medicaid program under title XIX  
24 of the Social Security Act (42 U.S.C. 1396 et  
25 seq.); or

1 (B) the TRICARE program under chapter  
2 55 of title 10, United States Code.

3 (c) HEALTH CARE PROVIDER DEFINED.—In this  
4 section, the term “health care provider” means—

5 (1) a physician, as defined in paragraphs (1),  
6 (2), (3), and (4) of section 1861(r) of the Social Se-  
7 curity Act (42 U.S.C. 1395x(r)); and

8 (2) a health care practitioner described in sec-  
9 tion 1842(b)(18)(C) of such Act (42 U.S.C.  
10 1395u(b)(18)(C)).

11 **TITLE X—QUALITY HEALTH**  
12 **CARE COALITION**

13 **SEC. 1001. QUALITY HEALTH CARE COALITION.**

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

17 (1) IN GENERAL.—Any health care profes-  
18 sionals who are engaged in negotiations with a  
19 health plan regarding the terms of any contract  
20 under which the professionals provide health care  
21 items or services for which benefits are provided  
22 under such plan shall, in connection with such nego-  
23 tiations, be exempt from the Federal antitrust laws.

24 (2) LIMITATION.—

1           (A) NO NEW RIGHT FOR COLLECTIVE CES-  
2           SATION OF SERVICE.—The exemption provided  
3           in paragraph (1) shall not confer any new right  
4           to participate in any collective cessation of serv-  
5           ice to patients not already permitted by existing  
6           law.

7           (B) NO CHANGE IN NATIONAL LABOR RE-  
8           LATIONS ACT.—This section applies only to  
9           health care professionals excluded from the Na-  
10          tional Labor Relations Act. Nothing in this sec-  
11          tion shall be construed as changing or amend-  
12          ing any provision of the National Labor Rela-  
13          tions Act, or as affecting the status of any  
14          group of persons under that Act.

15          (3) NO APPLICATION TO FEDERAL PRO-  
16          GRAMS.—Nothing in this section shall apply to nego-  
17          tiations between health care professionals and health  
18          plans pertaining to benefits provided under any of  
19          the following:

20                (A) The Medicare program under title  
21                XVIII of the Social Security Act (42 U.S.C.  
22                1395 et seq.).

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

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

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

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

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

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

14 (b) DEFINITIONS.—In this section, the following defi-  
15 nitions shall apply:

16 (1) ANTITRUST LAWS.—The term “antitrust  
17 laws”—

18 (A) has the meaning given it in subsection  
19 (a) of the first section of the Clayton Act (15  
20 U.S.C. 12(a)), except that such term includes  
21 section 5 of the Federal Trade Commission Act  
22 (15 U.S.C. 45) to the extent such section ap-  
23 plies to unfair methods of competition; and

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



1           (2) GROUP HEALTH PLAN.—The term “group  
2 health plan” means an employee welfare benefit plan  
3 to the extent that the plan provides medical care (in-  
4 cluding items and services paid for as medical care)  
5 to employees or their dependents (as defined under  
6 the terms of the plan) directly or through insurance,  
7 reimbursement, or otherwise.

8           (3) GROUP HEALTH PLAN, HEALTH INSURANCE  
9 ISSUER.—The terms “group health plan” and  
10 “health insurance issuer” include a third-party ad-  
11 ministrator or other person acting for or on behalf  
12 of such plan or issuer.

13           (4) HEALTH CARE SERVICES.—The term  
14 “health care services” means any services for which  
15 payment may be made under a health plan, includ-  
16 ing services related to the delivery or administration  
17 of such services.

18           (5) HEALTH CARE PROFESSIONAL.—The term  
19 “health care professional” means any individual or  
20 entity that provides health care items or services,  
21 treatment, assistance with activities of daily living,  
22 or medications to patients and who, to the extent re-  
23 quired by State or Federal law, possesses specialized  
24 training that confers expertise in the provision of

1 such items or services, treatment, assistance, or  
2 medications.

3 (6) HEALTH INSURANCE COVERAGE.—The term  
4 “health insurance coverage” means benefits con-  
5 sisting of medical care (provided directly, through  
6 insurance or reimbursement, or otherwise and in-  
7 cluding items and services paid for as medical care)  
8 under any hospital or medical service policy or cer-  
9 tificate, hospital or medical service plan contract, or  
10 health maintenance organization contract offered by  
11 a health insurance issuer.

12 (7) HEALTH INSURANCE ISSUER.—The term  
13 “health insurance issuer” means an insurance com-  
14 pany, insurance service, or insurance organization  
15 (including a health maintenance organization) that  
16 is licensed to engage in the business of insurance in  
17 a State and that is subject to State law regulating  
18 insurance. Such term does not include a group  
19 health plan.

20 (8) HEALTH MAINTENANCE ORGANIZATION.—  
21 The term “health maintenance organization”  
22 means—

23 (A) a federally qualified health mainte-  
24 nance organization (as defined in section

1           1301(a) of the Public Health Service Act (42  
2           U.S.C. 300e(a));

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

5           (C) a similar organization regulated under  
6           State law for solvency in the same manner and  
7           to the same extent as such a health mainte-  
8           nance organization.

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

12          (10) MEDICAL CARE.—The term “medical  
13          care” means amounts paid for—

14                (A) the diagnosis, cure, mitigation, treat-  
15                ment, or prevention of disease, or amounts paid  
16                for the purpose of affecting any structure or  
17                function of the body; and

18                (B) transportation primarily for and essen-  
19                tial to receiving items and services referred to  
20                in subparagraph (A).

21          (11) PERSON.—The term “person” includes a  
22          State or unit of local government.

23          (12) STATE.—The term “State” includes the  
24          several States, the District of Columbia, Puerto  
25          Rico, the Virgin Islands of the United States, Guam,

1 American Samoa, and the Commonwealth of the  
2 Northern Mariana Islands.

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

○