

115TH CONGRESS  
1ST SESSION

# H. R. 1072

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

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 15, 2017

Mr. SANFORD (for himself, Mr. DUNCAN of South Carolina, Mr. MEADOWS, Mr. GOSAR, Mr. GARRETT, and Mr. MOONEY of West Virginia) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

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

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

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

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

#### TITLE I—REPEALS

- Sec. 101. Repeal of individual and employer mandates.  
 Sec. 102. Repeal of Public Health Service Act provisions.  
 Sec. 103. Repeal of Patient Protection and Affordable Care Act provisions.  
 Sec. 104. Conforming and technical amendments.

#### TITLE II—TAXATION REFORM

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

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

##### Subtitle B—Health Savings Accounts

- Sec. 211. Repeal of contribution limitations.  
 Sec. 212. Freedom from mandate.  
 Sec. 213. Allowance of distributions for prescription and over-the-counter medicines and drugs.  
 Sec. 214. Purchase of health insurance from HSA.  
 Sec. 215. Special rule for certain medical expenses incurred before establishment of account.  
 Sec. 216. Administrative error correction before due date of return.  
 Sec. 217. Allowing HSA rollover to child or parent of account holder.  
 Sec. 218. Credit for contributions to an HSA.  
 Sec. 219. Equivalent bankruptcy protections for health savings accounts as retirement funds.  
 Sec. 220. Distributions for abortion expenses from health savings accounts included in gross income.

##### Subtitle C—Medical Expenses

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

##### Subtitle D—Miscellaneous

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

#### TITLE III—INDIVIDUAL HEALTH INSURANCE REFORM

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

#### TITLE IV—ASSOCIATION HEALTH PLANS

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

TITLE V—MEDICAID REFORM

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

TITLE VI—MISCELLANEOUS PROVISIONS

- Sec. 601. Certain medical stop-loss insurance obtained by certain plan sponsors of group health plans not included under the definition of health insurance coverage.  
 Sec. 602. Restoring the application of antitrust laws to health sector insurers.

1                   **TITLE I—REPEALS**

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

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

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

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

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

1 **SEC. 102. REPEAL OF PUBLIC HEALTH SERVICE ACT PROVI-**  
2 **SIONS.**

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

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

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

8 (3) Section 2703 (42 U.S.C. 300gg–2).

9 (4) Section 2704 (42 U.S.C. 300gg–3).

10 (5) Section 2705 (42 U.S.C. 300gg–4).

11 (6) Section 2707 (42 U.S.C. 300gg–6).

12 (7) Section 2708 (42 U.S.C. 300gg–7).

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

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

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

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

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

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

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

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

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

22 (17) Section 2794 (42 U.S.C. 300gg–94), relat-  
23 ing to ensuring that consumers get value for their  
24 dollars.

25 (b) REINSTATING PRE-PPACA LAW.—Sections  
26 2701, 2702, 2711, and 2712 of the Public Health Service

1 Act as in effect on the day before the date of enactment  
2 of the Patient Protection and Affordable Care Act (Public  
3 Law 111–148) shall be restored or revived as if such Act  
4 had not been enacted (subject to paragraphs (1), (2), (6),  
5 and (7) of subsection (c)).

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

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

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

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

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

24 (5) Section 2709 (42 U.S.C. 300gg–9), relating  
25 to disclosure of information, shall be redesignated as

1 section 2705 and transferred so as to appear after  
2 section 2704 (as so redesignated).

3 (6) Section 2711, as restored or revived under  
4 subsection (b), shall be redesignated as section 2706  
5 and transferred so as to appear after section 2705  
6 (as so redesignated).

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

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

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

18 (d) EFFECTIVE DATES.—

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

24 (2) DELAYED EFFECTIVE DATES.—The repeals  
25 under paragraphs (2), (3), (4), and (5) of subsection

1 (a), the provisions restored or revived under sub-  
2 section (b), and the conforming amendment in sec-  
3 tion 104(a)(2) shall be effective for plan years begin-  
4 ning on January 1, 2019, and (notwithstanding sub-  
5 section (c)) the provisions of law repealed by such  
6 paragraphs of subsection (a) or amended by such  
7 conforming amendment shall continue to remain in  
8 effect until such date.

9 **SEC. 103. REPEAL OF PATIENT PROTECTION AND AFFORD-**  
10 **ABLE CARE ACT PROVISIONS.**

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

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

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

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

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

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

8 (2) in section 2741(b)(3) (42 U.S.C. 300gg–  
9 41(a)(3)), by striking “2712” and inserting “2707”;

10 (3) in section 2751(a) (42 U.S.C. 300gg–  
11 51(a)), by striking “2704” and inserting “2725”;

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

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

18 (b) PPACA PROVISIONS.—The Patient Protection  
19 and Affordable Care Act (Public Law 111–148) is amend-  
20 ed—

21 (1) in section 1103(b)(1) (42 U.S.C.  
22 18003(b)(1))—

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



1 (B) by striking “and be consistent with the  
2 standards adopted for the uniform explanation  
3 of coverage as provided for in section 2715 of  
4 the Public Health Service Act”;

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

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

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

21 (4) in section 1302(e)(1)(B)(i) (42 U.S.C.  
22 18022(e)(1)(B)(i)), by striking “(except as provided  
23 for in section 2713)”;

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

25 (A) in subsection (c)—

1 (i) in paragraph (1)(B), by striking  
2 “(in a manner consistent with applicable  
3 network adequacy provisions under section  
4 2702(c) of the Public Health Service  
5 Act)”;

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

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

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

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

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

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

4 (1) in subsection (a)—

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

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

14 (2) by striking subsection (b).

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

17 (1) section 36B(b)(3)(C) is amended—

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

23 (B) by striking the second sentence;

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

25 and

1 (3) in section 9815—

2 (A) in subsection (a)—

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

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

13 (B) by striking subsection (b).

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

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

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

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

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

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

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

19             “(b) COORDINATION PROVISIONS.—

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

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

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

3 “(3) DEDUCTION FOR MEDICAL EXPENSES.—

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

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

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

14 (c) CONFORMING AMENDMENTS.—

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

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

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

“Sec. 224. Health insurance premiums.”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2017.

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

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

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

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

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

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

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

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

8 (b) CONFORMING AMENDMENTS.—

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

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

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

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to taxable years beginning after  
18 December 31, 2017.

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

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

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



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

7       (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (A) in subsection (c)(6)—

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

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

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

8                   “(b) RULES AND REQUIREMENTS.—

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

15                  “(2) COMPARABLE CONTRIBUTIONS.—

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

19                          “(i) which are the same amount, or

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

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

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

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

16          “(4) PART-TIME EMPLOYEES.—

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

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





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

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

8 (d) EFFECTIVE DATES.—

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

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

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

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

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

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

10 (c) EFFECTIVE DATE.—The amendments made by  
 11 this section shall apply with respect to insurance pur-  
 12 chased after the date of the enactment of this Act in tax-  
 13 able years beginning after such date.

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

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

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

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

4 “(i) during either—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(b) QUALIFIED HSA CONTRIBUTION.—

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

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

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

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

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

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

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

15 “(b) SPECIAL RULES.—

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

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

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

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

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

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

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

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



1 **SEC. 220. DISTRIBUTIONS FOR ABORTION EXPENSES FROM**  
2 **HEALTH SAVINGS ACCOUNTS INCLUDED IN**  
3 **GROSS INCOME.**

4 (a) IN GENERAL.—Subsection (e) of section 223 of  
5 the Internal Revenue Code of 1986, as amended by the  
6 preceding provisions of this subtitle, is amended by adding  
7 at the end the following new paragraph:

8 “(8) EXCEPTION FOR CERTAIN ABORTION EX-  
9 PENSES.—

10 “(A) IN GENERAL.—Notwithstanding para-  
11 graph (1), any amount used to pay for an abor-  
12 tion (other than an abortion described in sub-  
13 paragraph (B)) or health insurance that covers  
14 abortions (other than abortions so described)  
15 shall be included in the gross income of such  
16 beneficiary.

17 “(B) EXCEPTIONS.—Subparagraph (A)  
18 shall not apply to—

19 “(i) an abortion—

20 “(I) in the case of a pregnancy  
21 that is the result of an act of rape or  
22 incest, or

23 “(II) in the case where a woman  
24 suffers from a physical disorder, phys-  
25 ical injury, or physical illness that  
26 would, as certified by a physician,

1 place the woman in danger of death  
 2 unless an abortion is performed, in-  
 3 cluding a life-endangering physical  
 4 condition caused by or arising from  
 5 the pregnancy, and

6 “(ii) the treatment of any infection,  
 7 injury, disease, or disorder that has been  
 8 caused by or exacerbated by the perform-  
 9 ance of an abortion.”.

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 **Subtitle C—Medical Expenses**

#### 14 **SEC. 221. CERTAIN EXERCISE EQUIPMENT AND PHYSICAL** 15 **FITNESS PROGRAMS TREATED AS MEDICAL** 16 **CARE.**

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

20 “(12) EXERCISE EQUIPMENT AND PHYSICAL  
 21 FITNESS ACTIVITY.—

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

1           “(i) for equipment for use in a pro-  
2           gram (including a self-directed program) of  
3           physical exercise or physical activity,

4           “(ii) to participate, or receive instruc-  
5           tion, in a program of physical exercise, nu-  
6           trition, or health coaching (including a  
7           self-directed program), and

8           “(iii) for membership at a fitness fa-  
9           cility.

10          “(B) OVERALL DOLLAR LIMITATION.—

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

15           “(ii) EXCEPTION.—Clause (i) shall  
16           not apply for purposes of determining  
17           whether expenses reimbursed through a  
18           health flexible spending arrangement sub-  
19           ject to section 125(i)(1) are incurred for  
20           medical care.

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

1           “(i) if such equipment is utilized ex-  
2           clusively for participation in fitness, exer-  
3           cise, sport, or other physical activity pro-  
4           grams,

5           “(ii) if such equipment is not apparel  
6           or footwear, and

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

11          “(D) FITNESS FACILITY.—For purposes of  
12          subparagraph (A)(iii), the term ‘fitness facility’  
13          means a facility—

14               “(i) which provides instruction in a  
15               program of physical exercise, offers facili-  
16               ties for the preservation, maintenance, en-  
17               couragement, or development of physical  
18               fitness, or serves as the site of such a pro-  
19               gram of a State or local government,

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

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

1           “(iv) whose health or fitness facility is  
2           not incidental to its overall function and  
3           purpose, and

4           “(v) which is fully compliant with the  
5           State of jurisdiction and Federal anti-dis-  
6           crimination laws.”.

7           (b) LIMITATION NOT TO APPLY FOR CERTAIN PUR-  
8           POSES.—

9           (1) HEALTH SAVINGS ACCOUNTS.—Subpara-  
10          graph (A) of section 223(e)(2) of the Internal Rev-  
11          enue Code of 1986, as amended and redesignated by  
12          subtitle B, is further amended by inserting “, deter-  
13          mined without regard to paragraph (12)(B) there-  
14          of)” after “medical care (as defined in section  
15          213(d)”.

16          (2) ARCHER MSAS.—Subparagraph (A) of sec-  
17          tion 220(d)(2) of the Internal Revenue Code of  
18          1986, as amended by subtitle B, is further amended  
19          by inserting “, determined without regard to para-  
20          graph (12)(B) thereof” after “medical care (as de-  
21          fined in section 213(d)”.

22          (c) 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. 222. CERTAIN NUTRITIONAL AND DIETARY SUPPLE-**  
2 **MENTS TO BE TREATED AS MEDICAL CARE.**

3 (a) IN GENERAL.—Subsection (d) of section 213 of  
4 the Internal Revenue Code of 1986, as amended by section  
5 221, is further amended by adding at the end the following  
6 new paragraph:

7 “(13) NUTRITIONAL AND DIETARY SUPPLE-  
8 MENTS.—

9 “(A) IN GENERAL.—The term ‘medical  
10 care’ shall include amounts paid to purchase  
11 herbs, vitamins, minerals, homeopathic rem-  
12 edies, meal replacement products, and other di-  
13 etary and nutritional supplements.

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

18 “(C) MEAL REPLACEMENT PRODUCT.—  
19 For purposes of this paragraph, the term ‘meal  
20 replacement product’ means any product that—

21 “(i) is permitted to bear labeling mak-  
22 ing a claim described in section 403(r)(3)  
23 of the Federal Food, Drug, and Cosmetic  
24 Act, and

25 “(ii) is permitted to claim under such  
26 section that such product is low in fat and

1 is a good source of protein, fiber, and mul-  
2 tiple essential vitamins and minerals.

3 “(D) EXCEPTION.—Subparagraph (B)  
4 shall not apply for purposes of determining  
5 whether expenses reimbursed through a health  
6 flexible spending arrangement subject to section  
7 125(i)(1) are incurred for medical care.”.

8 (b) LIMITATION NOT TO APPLY FOR CERTAIN PUR-  
9 POSES.—

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

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

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

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

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

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

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

13 “(B) pre-paid primary care services de-  
14 signed to screen for, diagnose, cure, mitigate,  
15 treat, or prevent disease and promote  
16 wellness.”.

17 (b) EXCEPTION FOR FLEXIBLE SPENDING AC-  
18 COUNTS.—Section 125 of the Internal Revenue Code of  
19 1986 is amended by redesignating subsections (k) and (l)  
20 as subsections (l) and (m), respectively, and by inserting  
21 after subsection (j) the following new subsection:

22 “(k) SPECIAL RULE WITH RESPECT TO HEALTH  
23 FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of  
24 applying this section with respect to any health flexible  
25 spending arrangement, amounts described in section  
26 213(d)(14) shall not be considered insurance.”.



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

4 **SEC. 224. CLARIFICATION OF TREATMENT OF CAPITATED**  
5 **PRIMARY CARE PAYMENTS AS AMOUNTS**  
6 **PAID FOR MEDICAL CARE.**

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

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

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

17 **Subtitle D—Miscellaneous**

18 **SEC. 231. CONTRIBUTIONS OF MEDICARE BENEFICIARIES**  
19 **PARTICIPATING IN MEDICARE ADVANTAGE**  
20 **MSA.**

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

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

4 **SEC. 232. PHYSICIAN CHARITY AND UNCOMPENSATED**  
5 **CARE DEDUCTION.**

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

9 **“SEC. 199A. PHYSICIAN CHARITY AND UNCOMPENSATED**  
10 **CARE.**

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

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

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

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

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

24 “(2) QUALIFIED CHARITY CARE.—The term  
25 ‘qualified charity care’ means physicians’ services

1 provided on a volunteer or pro bono basis (not in-  
2 cluding any services for which an amount was  
3 charged but not paid).

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

8 “(c) LIMITATIONS.—

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

12 “(A) shall be reduced by any reimburse-  
13 ment received by the physician for such services  
14 or debt, and

15 “(B) shall not exceed the economic index  
16 referred to in the fourth sentence of section  
17 1842(b)(3) of the Social Security Act (42  
18 U.S.C. 1395u(b)(3)) applicable to the qualified  
19 charity care provided or the services provided  
20 with respect to which the debt relates.

21 In the case of physicians’ services to which such eco-  
22 nomic index is not applicable, the Secretary, in con-  
23 sultation with the Secretary of Health and Human  
24 Services, shall use data on uncompensated care for  
25 purposes of the limitation under subparagraph (B),

1 and may adjust such data so as to be an appropriate  
2 proxy, including (in the case of qualified charity  
3 care) a downward adjustment to eliminate bad debt  
4 data from uncompensated care data.

5 “(2) OVERALL LIMITATION.—The amount al-  
6 lowed as a deduction under subsection (a) for any  
7 taxable year shall not exceed an amount equal to 10  
8 percent of the gross income of the taxpayer for the  
9 taxable year derived from the taxpayer’s provision of  
10 physicians’ services.

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

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

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

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

1 **TITLE III—INDIVIDUAL HEALTH**  
 2 **INSURANCE REFORM**

3 **SEC. 301. POOL REFORM FOR INDIVIDUAL MEMBERSHIP**  
 4 **EXPANSION.**

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

7 **“TITLE XXXIV—POOL REFORM**  
 8 **FOR INDIVIDUAL MEMBER-**  
 9 **SHIP EXPANSION**

10 **“SEC. 3400. PURPOSE.**

11 “The purpose of this title is to provide, through the  
 12 establishment of independent health pools (referred to in  
 13 this title as ‘IHP’), for the reform of, and expansion of  
 14 enrollment in, health insurance coverage for individuals  
 15 and small employers.

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

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

20 “(1) ORGANIZATION.—The IHP—

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

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

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

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

9           “(E) does not receive any consideration di-  
10 rectly or indirectly from any health insurance  
11 issuer in connection with the enrollment of any  
12 individuals, or employees of employers, in any  
13 health insurance coverage, except in conjunction  
14 with services offered through the IHP.

15           “(2) OFFERING HEALTH BENEFITS COV-  
16 ERAGE.—

17           “(A) DIFFERENT GROUPS.—The IHP, in  
18 conjunction with those health insurance issuers  
19 that offer health benefits coverage through the  
20 IHP, makes available health benefits coverage  
21 in the manner described in subsection (b) to all  
22 members of the IHP and the dependents of  
23 such members (and, in the case of small em-  
24 ployers, employees and their dependents) in the  
25 manner described in subsection (c)(2) at rates

1 that are established by the health insurance  
2 issuer on a policy or product specific basis and  
3 that may vary for individuals covered through  
4 an IHP.

5 “(B) NONDISCRIMINATION IN COVERAGE  
6 OFFERED.—

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

12 “(ii) CONSTRUCTION.—Nothing in  
13 this title shall be construed as requiring or  
14 permitting a health insurance issuer to  
15 provide coverage outside the service area of  
16 the issuer, as approved under State law, or  
17 preventing a health insurance issuer from  
18 underwriting or from excluding or limiting  
19 the coverage on any individual, subject to  
20 the requirement of section 2741 (relating  
21 to guaranteed availability of individual  
22 health insurance coverage to certain indi-  
23 viduals with prior group coverage).

24 “(C) NO ASSUMPTION OF INSURANCE RISK  
25 BY IHP.—The IHP provides health benefits cov-

1           erage only through contracts with health insur-  
2           ance issuers and does not assume insurance  
3           risk with respect to such coverage.

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

9           “(4) PROVISION OF ADMINISTRATIVE SERVICES  
10          TO PURCHASERS.—The IHP may provide adminis-  
11          trative services for members. Such services may in-  
12          clude accounting, billing, and enrollment informa-  
13          tion.

14          “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
15          MENTS.—

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

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

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



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

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

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

16                 “(1) MEMBERS.—

17                         “(A) IN GENERAL.—Under rules estab-  
18                         lished to carry out this title, with respect to an  
19                         individual or small employer who is a member  
20                         of an IHP, the individual may enroll for health  
21                         benefits coverage (including coverage for de-  
22                         pendents of such individual) or the employer  
23                         may enroll employees for health benefits cov-  
24                         erage (including coverage for dependents of

1 such employees) offered by a health insurance  
2 issuer through the IHP.

3 “(B) RULES FOR ENROLLMENT.—Nothing  
4 in this paragraph shall preclude an IHP from  
5 establishing rules of enrollment and reenroll-  
6 ment of members. Such rules shall be applied  
7 consistently to all members within the IHP and  
8 shall not be based in any manner on health sta-  
9 tus-related factors.

10 “(2) HEALTH INSURANCE ISSUERS.—The con-  
11 tract between an IHP and a health insurance issuer  
12 shall provide, with respect to a member enrolled with  
13 health benefits coverage offered by the issuer  
14 through the IHP, for the payment to the issuer of  
15 the premiums (if any) collected by the IHP for  
16 health insurance coverage offered by the issuer.

17 **“SEC. 3402. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
18 **MENTS.**

19 “(a) PREEMPTION OF STATE LAWS RESTRICTING  
20 FORMATION OF IHPS.—Any State law or regulation relat-  
21 ing to the composition or organization of an IHP is pre-  
22 empted to the extent the law or regulation is inconsistent  
23 with the provisions of this title.

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

1 “(1) BENEFIT REQUIREMENTS.—

2 “(A) IN GENERAL.—Subject to subpara-  
3 graph (B), State laws are superseded, and shall  
4 not apply to health benefits coverage made  
5 available through an IHP, insofar as such laws  
6 impose benefit requirements for such coverage,  
7 including requirements relating to coverage of  
8 specific providers, specific services or condi-  
9 tions, or the amount, duration, or scope of ben-  
10 efits.

11 “(B) EXCEPTION FOR FEDERALLY IM-  
12 POSED REQUIREMENTS AND FOR REQUIRE-  
13 MENTS PROHIBITING DISEASE-SPECIFIC EXCLU-  
14 SIONS.—Subparagraph (A) shall not apply to a  
15 requirement to the extent the requirement—

16 “(i) implements title XXVII or other  
17 Federal law; or

18 “(ii) prohibits imposition of an exclu-  
19 sion of a specific disease from health bene-  
20 fits coverage.

21 “(2) OTHER REQUIREMENTS PREVENTING OF-  
22 FERING OF COVERAGE THROUGH AN IHP.—State  
23 laws are superseded, and shall not apply to health  
24 benefits coverage made available through an IHP,  
25 insofar as such laws impose any other requirements

1 (including limitations on compensation arrange-  
2 ments) that, directly or indirectly, preclude (or have  
3 the effect of precluding) the offering of such cov-  
4 erage through an IHP, if the IHP meets the re-  
5 quirements of this title.

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

12 **“SEC. 3403. DEFINITIONS.**

13 “For purposes of this title:

14 “(1) DEPENDENT.—The term ‘dependent’, as  
15 applied to health insurance coverage offered by a  
16 health insurance issuer licensed (or otherwise regu-  
17 lated) in a State, shall have the meaning applied to  
18 such term with respect to such coverage under the  
19 laws of the State relating to such coverage and such  
20 an issuer. Such term may include the spouse and  
21 children of the individual involved.

22 “(2) HEALTH BENEFITS COVERAGE.—The term  
23 ‘health benefits coverage’ has the meaning given the  
24 term ‘health insurance coverage’ in section

1 2791(b)(1), and does not include excepted benefits  
2 (as defined in section 2791(c)).

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

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

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

14 “(6) SMALL EMPLOYER.—The term ‘small em-  
15 ployer’ has the meaning given such term in section  
16 712(c)(1)(B) of the Employee Retirement and In-  
17 come Security Act of 1974.”.

18 **SEC. 302. COOPERATIVE GOVERNING OF INDIVIDUAL**  
19 **HEALTH INSURANCE COVERAGE.**

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

1           **“PART D—COOPERATIVE GOVERNING OF**  
2           **INDIVIDUAL HEALTH INSURANCE COVERAGE**

3           **“SEC. 2795. DEFINITIONS.**

4           “In this part:

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

20                   “(2) SECONDARY STATE.—The term ‘secondary  
21          State’ means, with respect to individual health insur-  
22          ance coverage offered by a health insurance issuer,  
23          any State that is not the primary State. In the case  
24          of a health insurance issuer that is selling a policy  
25          in, or to a resident of, a secondary State, the issuer

1 is deemed to be doing business in that secondary  
2 State.

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

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

14 “(5) 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 this title for the State with respect to the issuer.

20 “(6) HAZARDOUS FINANCIAL CONDITION.—The  
21 term ‘hazardous financial condition’ means that,  
22 based on its present or reasonably anticipated finan-  
23 cial condition, a health insurance issuer is unlikely  
24 to be able—

1           “(A) to meet obligations to policyholders  
2 with respect to known claims and reasonably  
3 anticipated claims; or

4           “(B) to pay other obligations in the normal  
5 course of business.

6           “(7) COVERED LAWS.—

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

11           “(i) individual health insurance cov-  
12 erage issued by a health insurance issuer;

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

17           “(iii) the provision to an individual in  
18 relation to individual health insurance cov-  
19 erage of health care and insurance related  
20 services;

21           “(iv) the provision to an individual in  
22 relation to individual health insurance cov-  
23 erage of management, operations, and in-  
24 vestment activities of a health insurance  
25 issuer; and



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

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

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

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

21                 “(A) Knowingly misrepresenting to claim-  
22                 ants and insured individuals relevant facts or  
23                 policy provisions relating to coverage at issue.

1           “(B) Failing to acknowledge with reason-  
2           able promptness pertinent communications with  
3           respect to claims arising under policies.

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

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

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

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

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

22          “(H) A pattern or practice of attempting  
23          to settle or settling claims for less than the  
24          amount that a reasonable person would believe  
25          the insured individual or his or her beneficiary

1 was entitled by reference to written or printed  
2 advertising material accompanying or made  
3 part of an application.

4 “(I) Attempting to settle or settling claims  
5 on the basis of an application that was materi-  
6 ally altered without notice to, or knowledge or  
7 consent of, the insured.

8 “(J) Failing to provide forms necessary to  
9 present claims within 15 calendar days of re-  
10 quests with reasonable explanations regarding  
11 their use.

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

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

20 “(A) Presenting, causing to be presented,  
21 or preparing with knowledge or belief that it  
22 will be presented to or by an insurer, a rein-  
23 surer, or broker or its agent, false information  
24 as part of, in support of, or concerning a fact  
25 material to one or more of the following:

1           “(i) An application for the issuance or  
2 renewal of an insurance policy or reinsur-  
3 ance contract.

4           “(ii) The rating of an insurance policy  
5 or reinsurance contract.

6           “(iii) A claim for payment or benefit  
7 pursuant to an insurance policy or reinsur-  
8 ance contract.

9           “(iv) Premiums paid on an insurance  
10 policy or reinsurance contract.

11           “(v) Payments made in accordance  
12 with the terms of an insurance policy or  
13 reinsurance contract.

14           “(vi) A document filed with the com-  
15 missioner or the chief insurance regulatory  
16 official of another jurisdiction.

17           “(vii) The financial condition of an in-  
18 surer or reinsurer.

19           “(viii) The formation, acquisition,  
20 merger, reconsolidation, dissolution or  
21 withdrawal from one or more lines of in-  
22 surance or reinsurance in all or part of a  
23 State by an insurer or reinsurer.

24           “(ix) The issuance of written evidence  
25 of insurance.

1                   “(x) The reinstatement of an insur-  
2                   ance policy.

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

10                  “(C) Transaction of the business of insur-  
11                  ance in violation of laws requiring a license, cer-  
12                  tificate of authority, or other legal authority for  
13                  the transaction of the business of insurance.

14                  “(D) Attempt to commit, aiding or abet-  
15                  ting in the commission of, or conspiracy to com-  
16                  mit the acts or omissions specified in this para-  
17                  graph.

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

19                  “(a) IN GENERAL.—The covered laws of the primary  
20 State shall apply to individual health insurance coverage  
21 offered by a health insurance issuer in the primary State  
22 and in any secondary State, but only if the coverage and  
23 issuer comply with the conditions of this section with re-  
24 spect to the offering of coverage in any secondary State.

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

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

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

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

23           “(C) to submit to an examination of its fi-  
24   nancial condition by the State insurance com-  
25   missioner in any State in which the issuer is

1           doing business to determine the issuer’s finan-  
2           cial condition, if—

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

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

14                  “(D) to comply with a lawful order  
15                  issued—

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

21                   “(ii) in a voluntary dissolution pro-  
22                   ceeding;

23                  “(E) to comply with an injunction issued  
24                  by a court of competent jurisdiction, upon a pe-  
25                  tition by the State insurance commissioner al-

1           leging that the issuer is in hazardous financial  
2           condition;

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

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

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

17          “(I) to comply with the applicable require-  
18          ments for independent review under section  
19          2798 with respect to coverage offered in the  
20          State;

21          “(2) require any individual health insurance  
22          coverage issued by the issuer to be countersigned by  
23          an insurance agent or broker residing in that sec-  
24          ondary State; or





1 should carefully review the policy and determine what  
2 health care services the policy covers and what benefits  
3 it provides, including any exclusions, limitations, or condi-  
4 tions for such services or benefits.’.

5 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
6 AND PREMIUM INCREASES.—

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

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

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

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

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

4           “(B) from raising premium rates for all  
5 policy holders within a class based on claims ex-  
6 perience;

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

12                   “(i) are disclosed to the consumer in  
13 the insurance contract;

14                   “(ii) are based on specific wellness ac-  
15 tivities that are not applicable to all indi-  
16 viduals; and

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

19           “(D) from reinstating lapsed coverage; or

20           “(E) from retroactively adjusting the rates  
21 charged an insured individual if the initial rates  
22 were set based on material misrepresentation by  
23 the individual at the time of issue.

24           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
25 STATE.—A health insurance issuer may not offer for sale

1 individual health insurance coverage in a secondary State  
2 unless that coverage is currently offered for sale in the  
3 primary State.

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

14       “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
15 SURANCE COMMISSIONER.—Each health insurance issuer  
16 issuing individual health insurance coverage in both pri-  
17 mary and secondary States shall submit—

18               “(1) to the insurance commissioner of each  
19 State in which it intends to offer such coverage, be-  
20 fore it may offer individual health insurance cov-  
21 erage in such State—

22                       “(A) a copy of the plan of operation or fea-  
23 sibility study or any similar statement of the  
24 policy being offered and its coverage (which

1 shall include the name of its primary State and  
2 its principal place of business);

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

5 “(C) written notice from the issuer of the  
6 issuer’s compliance with all the laws of the pri-  
7 mary State; and

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

16 “(A) a member of the American Academy  
17 of Actuaries; or

18 “(B) a qualified loss reserve specialist.

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

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

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

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

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

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

19           “(2) COURTS OF COMPETENT JURISDICTION.—

20 If a State seeks an injunction regarding the conduct  
21 described in paragraphs (1) and (2) of subsection  
22 (h), such injunction must be obtained from a Fed-  
23 eral or State court of competent jurisdiction.

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

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

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

21 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
22 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
23 **STATES.**

24       “A health insurance issuer may not offer, sell, or  
25 issue individual health insurance coverage in a secondary

1 State if the State insurance commissioner does not use  
2 a risk-based capital formula for the determination of cap-  
3 ital and surplus requirements for all health insurance  
4 issuers.

5 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
6 **DURES.**

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

11 “(1) both the secondary State and the primary  
12 State have legislation or regulations in place estab-  
13 lishing an independent review process for individuals  
14 who are covered by individual health insurance cov-  
15 erage; or

16 “(2) in any case in which the requirements of  
17 paragraph (1) are not met with respect to the either  
18 of such States, the issuer provides an independent  
19 review mechanism substantially identical (as deter-  
20 mined by the applicable State authority of such  
21 State) to that prescribed in the ‘Health Carrier Ex-  
22 ternal Review Model Act’ of the National Association  
23 of Insurance Commissioners for all individuals who  
24 purchase insurance coverage under the terms of this  
25 part, except that, under such mechanism, the review



1 is conducted by an independent medical reviewer, or  
2 a panel of such reviewers, with respect to whom the  
3 requirements of subsection (b) are met.

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

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

11 “(A) each independent medical reviewer  
12 meets the qualifications described in paragraphs  
13 (2) and (3);

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

19 “(C) compensation provided by the issuer  
20 to each reviewer is consistent with paragraph  
21 (6).

22 “(2) LICENSURE AND EXPERTISE.—Each inde-  
23 pendent medical reviewer shall be a physician  
24 (allopathic or osteopathic) or health care profes-  
25 sional who—

1           “(A) is appropriately credentialed or li-  
2 censed in one or more States to deliver health  
3 care services; and

4           “(B) typically treats the condition, makes  
5 the diagnosis, or provides the type of treatment  
6 under review.

7           “(3) INDEPENDENCE.—

8           “(A) IN GENERAL.—Subject to subpara-  
9 graph (B), each independent medical reviewer  
10 in a case shall—

11                   “(i) not be a related party (as defined  
12 in paragraph (7));

13                   “(ii) not have a material familial, fi-  
14 nancial, or professional relationship with  
15 such a party; and

16                   “(iii) not otherwise have a conflict of  
17 interest with such a party (as determined  
18 under regulations).

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

21                   “(i) prohibit an individual, solely on  
22 the basis of affiliation with the issuer,  
23 from serving as an independent medical re-  
24 viewer if—

1                   “(I) a non-affiliated individual is  
2                   not reasonably available;

3                   “(II) the affiliated individual is  
4                   not involved in the provision of items  
5                   or services in the case under review;

6                   “(III) the fact of such an affili-  
7                   ation is disclosed to the issuer and the  
8                   enrollee (or authorized representative)  
9                   and neither party objects; and

10                  “(IV) the affiliated individual is  
11                  not an employee of the issuer and  
12                  does not provide services exclusively or  
13                  primarily to or on behalf of the issuer;

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

22                  “(iii) prohibit receipt of compensation  
23                  by an independent medical reviewer from  
24                  an entity if the compensation is provided  
25                  consistent with paragraph (6).

1           “(4) PRACTICING HEALTH CARE PROFESSIONAL  
2           IN SAME FIELD.—

3           “(A) IN GENERAL.—In a case involving  
4           treatment, or the provision of items or serv-  
5           ices—

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

15                  “(ii) by a non-physician health care  
16                  professional, the reviewer, or at least one  
17                  member of the review panel, shall be a  
18                  practicing non-physician health care pro-  
19                  fessional of the same or similar specialty  
20                  as the non-physician health care profes-  
21                  sional who, acting within the appropriate  
22                  scope of practice within the State in which  
23                  the service is provided or rendered, typi-  
24                  cally treats the condition, makes the diag-

1           nosis, or provides the type of treatment  
2           under review.

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

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

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

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

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

20          “(7) RELATED PARTY DEFINED.—For purposes  
21          of this section, the term ‘related party’ means, with  
22          respect to a denial of a claim under a coverage relat-  
23          ing to an enrollee, any of the following:

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

1           “(B) The enrollee (or authorized represent-  
2           ative).

3           “(C) The health care professional that pro-  
4           vides the items or services involved in the de-  
5           nial.

6           “(D) The institution at which the items or  
7           services (or treatment) involved in the denial  
8           are provided.

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

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

15          “(8) DEFINITIONS.—For purposes of this sub-  
16          section—

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

22                 “(B) HEALTH CARE PROFESSIONAL.—The  
23                 term ‘health care professional’ means an indi-  
24                 vidual who is licensed, accredited, or certified  
25                 under State law to provide specified health care

1 services and who is operating within the scope  
2 of such licensure, accreditation, or certification.

3 **“SEC. 2799. ENFORCEMENT.**

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

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

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

17 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
18 of individual health insurance coverage offered in a sec-  
19 ondary State that fails to comply with the covered laws  
20 of the primary State, the applicable State authority of the  
21 secondary State may notify the applicable State authority  
22 of the primary State.”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall apply to individual health insurance

1 coverage offered, issued, or sold after the date that is one  
2 year after the date of the enactment of this Act.

3 (c) GAO ONGOING STUDY AND REPORTS.—

4 (1) STUDY.—The Comptroller General of the  
5 United States shall conduct an ongoing study con-  
6 cerning the effect of the amendment made by sub-  
7 section (a) on—

8 (A) the number of uninsured and under-  
9 insured;

10 (B) the availability and cost of health in-  
11 surance policies for individuals with pre-existing  
12 medical conditions;

13 (C) the availability and cost of health in-  
14 surance policies generally;

15 (D) the elimination or reduction of dif-  
16 ferent types of benefits under health insurance  
17 policies offered in different States; and

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

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



1                   **TITLE IV—ASSOCIATION**  
2                   **HEALTH PLANS**

3 **SEC. 401. RULES GOVERNING ASSOCIATION HEALTH**  
4                   **PLANS.**

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

8           **“PART 8—RULES GOVERNING ASSOCIATION**  
9                   **HEALTH PLANS**

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

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

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

17                   “(1) is organized and maintained in good faith,  
18                   with a constitution and bylaws specifically stating its  
19                   purpose and providing for periodic meetings on at  
20                   least an annual basis, as a bona fide trade associa-  
21                   tion, a bona fide industry association (including a  
22                   rural electric cooperative association or a rural tele-  
23                   phone cooperative association), a bona fide profes-  
24                   sional association, or a bona fide chamber of com-  
25                   merce (or similar bona fide business association, in-

1 including a corporation or similar organization that  
2 operates on a cooperative basis (within the meaning  
3 of section 1381 of the Internal Revenue Code of  
4 1986)), for substantial purposes other than that of  
5 obtaining or providing medical care;

6 “(2) is established as a permanent entity which  
7 receives the active support of its members and re-  
8 quires for membership payment on a periodic basis  
9 of dues or payments necessary to maintain eligibility  
10 for membership in the sponsor; and

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

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

22 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
23 **PLANS.**

24 “(a) IN GENERAL.—The applicable authority shall  
25 prescribe by regulation a procedure under which, subject

1 to subsection (b), the applicable authority shall certify as-  
2 sociation health plans which apply for certification as  
3 meeting the requirements of this part.

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

13 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
14 PLANS.—An association health plan with respect to which  
15 certification under this part is in effect shall meet the ap-  
16 plicable requirements of this part, effective on the date  
17 of certification (or, if later, on the date on which the plan  
18 is to commence operations).

19 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
20 CATION.—The applicable authority may provide by regula-  
21 tion for continued certification of association health plans  
22 under this part.

23 “(e) CLASS CERTIFICATION FOR FULLY INSURED  
24 PLANS.—The applicable authority shall establish a class  
25 certification procedure for association health plans under

1 which all benefits consist of health insurance coverage.  
2 Under such procedure, the applicable authority shall pro-  
3 vide for the granting of certification under this part to  
4 the plans in each class of such association health plans  
5 upon appropriate filing under such procedure in connec-  
6 tion with plans in such class and payment of the pre-  
7 scribed fee under section 807(a).

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

13               “(1) a plan which offered such coverage on the  
14 date of the enactment of the Obamacare Replace-  
15 ment Act;

16               “(2) a plan under which the sponsor does not  
17 restrict membership to one or more trades and busi-  
18 nesses or industries and whose eligible participating  
19 employers represent a broad cross-section of trades  
20 and businesses or industries; or

21               “(3) a plan whose eligible participating employ-  
22 ers represent one or more trades or businesses, or  
23 one or more industries, consisting of any of the fol-  
24 lowing: agriculture; equipment and automobile deal-  
25 erships; barbering and cosmetology; certified public

1 accounting practices; child care; construction; dance,  
2 theatrical and orchestra productions; disinfecting  
3 and pest control; financial services; fishing; food  
4 service establishments; hospitals; labor organiza-  
5 tions; logging; manufacturing (metals); mining; med-  
6 ical and dental practices; medical laboratories; pro-  
7 fessional consulting services; sanitary services; trans-  
8 portation (local and freight); warehousing; whole-  
9 saling/distributing; or any other trade or business or  
10 industry which has been indicated as having average  
11 or above-average risk or health claims experience by  
12 reason of State rate filings, denials of coverage, pro-  
13 posed premium rate levels, or other means dem-  
14 onstrated by such plan in accordance with regula-  
15 tions.

16 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
17 **BOARDS OF TRUSTEES.**

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

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

4           “(1) FISCAL CONTROL.—The plan is operated,  
5 pursuant to a trust agreement, by a board of trust-  
6 ees which has complete fiscal control over the plan  
7 and which is responsible for all operations of the  
8 plan.

9           “(2) RULES OF OPERATION AND FINANCIAL  
10 CONTROLS.—The board of trustees has in effect  
11 rules of operation and financial controls, based on a  
12 3-year plan of operation, adequate to carry out the  
13 terms of the plan and to meet all requirements of  
14 this title applicable to the plan.

15           “(3) RULES GOVERNING RELATIONSHIP TO  
16 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
17 TORS.—

18           “(A) BOARD MEMBERSHIP.—

19           “(i) IN GENERAL.—Except as pro-  
20 vided in clauses (ii) and (iii), the members  
21 of the board of trustees are individuals se-  
22 lected from individuals who are the owners,  
23 officers, directors, or employees of the par-  
24 ticipating employers or who are partners in

1 the participating employers and actively  
2 participate in the business.

3 “(ii) LIMITATION.—

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

10 “(II) LIMITED EXCEPTION FOR  
11 PROVIDERS OF SERVICES SOLELY ON  
12 BEHALF OF THE SPONSOR.—Officers  
13 or employees of a sponsor which is a  
14 service provider (other than a contract  
15 administrator) to the plan may be  
16 members of the board if they con-  
17 stitute not more than 25 percent of  
18 the membership of the board and they  
19 do not provide services to the plan  
20 other than on behalf of the sponsor.

21 “(III) TREATMENT OF PRO-  
22 VIDERS OF MEDICAL CARE.—In the  
23 case of a sponsor which is an associa-  
24 tion whose membership consists pri-  
25 marily of providers of medical care,

1                   subclause (I) shall not apply in the  
2                   case of any service provider described  
3                   in subclause (I) who is a provider of  
4                   medical care under the plan.

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

10                  “(B) SOLE AUTHORITY.—The board has  
11                  sole authority under the plan to approve appli-  
12                  cations for participation in the plan and to con-  
13                  tract with a service provider to administer the  
14                  day-to-day affairs of the plan.

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

19                  “(1) the requirements of subsection (a) and sec-  
20                  tion 801(a) shall be deemed met if such require-  
21                  ments would otherwise be met if the franchiser were  
22                  deemed to be the sponsor referred to in section  
23                  801(b), such network were deemed to be an associa-  
24                  tion described in section 801(b), and each franchisee



1 were deemed to be a member (of the association and  
2 the sponsor) referred to in section 801(b); and

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

5 The Secretary may by regulation define for purposes of  
6 this subsection the terms ‘franchiser’, ‘franchise network’,  
7 and ‘franchisee’.

8 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
9 **MENTS.**

10 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
11 requirements of this subsection are met with respect to  
12 an association health plan if, under the terms of the  
13 plan—

14 “(1) each participating employer must be—

15 “(A) a member of the sponsor;

16 “(B) the sponsor; or

17 “(C) an affiliated member of the sponsor

18 with respect to which the requirements of sub-

19 section (b) are met,

20 except that, in the case of a sponsor which is a pro-

21 fessional association or other individual-based asso-

22 ciation, if at least one of the officers, directors, or

23 employees of an employer, or at least one of the in-

24 dividuals who are partners in an employer and who

25 actively participates in the business, is a member or

1 such an affiliated member of the sponsor, partici-  
2 pating employers may also include such employer;  
3 and

4 “(2) all individuals commencing coverage under  
5 the plan after certification under this part must  
6 be—

7 “(A) active or retired owners (including  
8 self-employed individuals), officers, directors, or  
9 employees of, or partners in, participating em-  
10 ployers; or

11 “(B) the beneficiaries of individuals de-  
12 scribed in subparagraph (A).

13 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
14 PLOYEES.—In the case of an association health plan in  
15 existence on the date of the enactment of the Obamacare  
16 Replacement Act, an affiliated member of the sponsor of  
17 the plan may be offered coverage under the plan as a par-  
18 ticipating employer only if—

19 “(1) the affiliated member was an affiliated  
20 member on the date of certification under this part;  
21 or

22 “(2) during the 12-month period preceding the  
23 date of the offering of such coverage, the affiliated  
24 member has not maintained or contributed to a  
25 group health plan with respect to any of its employ-

1       ees who would otherwise be eligible to participate in  
2       such association health plan.

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

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

19             “(1) under the terms of the plan, all employers  
20             meeting the preceding requirements of this section  
21             are eligible to qualify as participating employers for  
22             all geographically available coverage options, unless,  
23             in the case of any such employer, participation or  
24             contribution requirements of the type referred to in

1 section 2711 of the Public Health Service Act are  
2 not met;

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

6 “(3) the applicable requirements of sections  
7 701, 702, and 703 are met with respect to the plan.

8 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
9 **DOCUMENTS, CONTRIBUTION RATES, AND**  
10 **BENEFIT OPTIONS.**

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

14 “(1) CONTENTS OF GOVERNING INSTRU-  
15 MENTS.—The instruments governing the plan in-  
16 clude a written instrument, meeting the require-  
17 ments of an instrument required under section  
18 402(a)(1), which—

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

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

4           “(C) incorporates the requirements of sec-  
5 tion 806.

6           “(2) CONTRIBUTION RATES MUST BE NON-  
7 DISCRIMINATORY.—

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

15           “(B) Nothing in this title or any other pro-  
16 vision of law shall be construed to preclude an  
17 association health plan, or a health insurance  
18 issuer offering health insurance coverage in  
19 connection with an association health plan,  
20 from—

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

23           “(ii) varying contribution rates for  
24 small employers in a State to the extent  
25 that such rates could vary using the same

1 methodology employed in such State for  
2 regulating premium rates in the small  
3 group market with respect to health insur-  
4 ance coverage offered in connection with  
5 bona fide associations (within the meaning  
6 of section 2791(d)(3) of the Public Health  
7 Service Act),

8 subject to the requirements of section 702(b)  
9 relating to contribution rates.

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

16 “(4) MARKETING REQUIREMENTS.—

17 “(A) IN GENERAL.—If a benefit option  
18 which consists of health insurance coverage is  
19 offered under the plan, State-licensed insurance  
20 agents shall be used to distribute to small em-  
21 ployers coverage which does not consist of  
22 health insurance coverage in a manner com-  
23 parable to the manner in which such agents are  
24 used to distribute health insurance coverage.

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

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

15                  “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
16                  DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
17                  nothing in this part or any provision of State law (as de-  
18                  fined in section 514(c)(1)) shall be construed to preclude  
19                  an association health plan, or a health insurance issuer  
20                  offering health insurance coverage in connection with an  
21                  association health plan, from exercising its sole discretion  
22                  in selecting the specific items and services consisting of  
23                  medical care to be included as benefits under such plan  
24                  or coverage, except (subject to section 514) in the case  
25                  of (1) any law to the extent that it is not preempted under

1 section 731(a)(1) with respect to matters governed by sec-  
2 tion 711, 712, or 713, or (2) any law of the State with  
3 which filing and approval of a policy type offered by the  
4 plan was initially obtained to the extent that such law pro-  
5 hibits an exclusion of a specific disease from such cov-  
6 erage.

7 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
8 **FOR SOLVENCY FOR PLANS PROVIDING**  
9 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
10 **INSURANCE COVERAGE.**

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

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

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

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

22 “(i) a reserve sufficient for unearned  
23 contributions;

24 “(ii) a reserve sufficient for benefit li-  
25 abilities which have been incurred, which



1 have not been satisfied, and for which risk  
2 of loss has not yet been transferred, and  
3 for expected administrative costs with re-  
4 spect to such benefit liabilities;

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

7 “(iv) a reserve sufficient for a margin  
8 of error and other fluctuations, taking into  
9 account the specific circumstances of the  
10 plan; and

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

16 “(i) The plan shall secure aggregate  
17 excess/stop loss insurance for the plan with  
18 an attachment point which is not greater  
19 than 125 percent of expected gross annual  
20 claims. The applicable authority may by  
21 regulation provide for upward adjustments  
22 in the amount of such percentage in speci-  
23 fied circumstances in which the plan spe-  
24 cifically provides for and maintains re-

1 serves in excess of the amounts required  
2 under subparagraph (A).

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

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

18 Any person issuing to a plan insurance described in clause  
19 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
20 retary of any failure of premium payment meriting can-  
21 cellation of the policy prior to undertaking such a cancella-  
22 tion. Any regulations prescribed by the applicable author-  
23 ity pursuant to clause (i) or (ii) of subparagraph (B) may  
24 allow for such adjustments in the required levels of excess/  
25 stop loss insurance as the qualified health actuary may

1 recommend, taking into account the specific circumstances  
2 of the plan.

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

8 “(1) \$500,000; or

9 “(2) such greater amount (but not greater than  
10 \$2,000,000) as may be set forth in regulations pre-  
11 scribed by the applicable authority, considering the  
12 level of aggregate and specific excess/stop loss insur-  
13 ance provided with respect to such plan and other  
14 factors related to solvency risk, such as the plan’s  
15 projected levels of participation or claims, the nature  
16 of the plan’s liabilities, and the types of assets avail-  
17 able to assure that such liabilities are met.

18 “(c) ADDITIONAL REQUIREMENTS.—In the case of  
19 any association health plan described in subsection (a)(2),  
20 the applicable authority may provide such additional re-  
21 quirements relating to reserves, excess/stop loss insurance,  
22 and indemnification insurance as the applicable authority  
23 considers appropriate. Such requirements may be provided  
24 by regulation with respect to any such plan or any class  
25 of such plans.

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

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

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

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

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

22               “(B) PENALTIES FOR FAILURE TO MAKE  
23 PAYMENTS.—If any payment is not made by a  
24 plan when it is due, a late payment charge of  
25 not more than 100 percent of the payment

1           which was not timely paid shall be payable by  
2           the plan to the Fund.

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

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

1 payments, claims would not be satisfied by reason of  
2 termination of such coverage. The Secretary shall, to  
3 the extent provided in advance in appropriation  
4 Acts, pay such amounts so determined to the insurer  
5 designated by the Secretary.

6 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

16 “(B) INVESTMENT.—Whenever the Sec-  
17 retary determines that the moneys of the fund  
18 are in excess of current needs, the Secretary  
19 may request the investment of such amounts as  
20 the Secretary determines advisable by the Sec-  
21 retary of the Treasury in obligations issued or  
22 guaranteed by the United States.

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

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

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

11           “(B) which is guaranteed renewable; and

12           “(C) which allows for payment of pre-  
13 miums by any third party on behalf of the in-  
14 sured plan.

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

19           “(A) under which an insurer (meeting such  
20 minimum standards as the applicable authority  
21 may prescribe by regulation) provides for pay-  
22 ment to the plan with respect to claims under  
23 the plan in connection with a covered individual  
24 in excess of an amount or amounts specified in



1           such contract in connection with such covered  
2           individual;

3                   “(B) which is guaranteed renewable; and

4                   “(C) which allows for payment of pre-  
5           miums by any third party on behalf of the in-  
6           sured plan.

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

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

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

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

23           “(i) RESERVES.—For purposes of this section, the  
24 term ‘reserves’ means, in connection with an association  
25 health plan, plan assets which meet the fiduciary stand-

1 ards under part 4 and such additional requirements re-  
2 garding liquidity as the applicable authority may prescribe  
3 by regulation.

4 “(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

18 “(A) A representative of the National As-  
19 sociation of Insurance Commissioners.

20 “(B) A representative of the American  
21 Academy of Actuaries.

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

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

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

4           “(F) A representative of multiemployer  
5           plans that are group health plans, or their in-  
6           terests.

7   **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
8                           **LATED REQUIREMENTS.**

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

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

24           “(1) **IDENTIFYING INFORMATION.**—The names  
25           and addresses of—

1           “(A) the sponsor; and

2           “(B) the members of the board of trustees  
3           of the plan.

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

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

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

20          “(5) AGREEMENTS WITH SERVICE PRO-  
21          VIDERS.—A copy of any agreements between the  
22          plan and contract administrators and other service  
23          providers.

24          “(6) FUNDING REPORT.—In the case of asso-  
25          ciation health plans providing benefits options in ad-

1       dition to health insurance coverage, a report setting  
2       forth information with respect to such additional  
3       benefit options determined as of a date within the  
4       120-day period ending with the date of the applica-  
5       tion, including the following:

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

13             “(B) ADEQUACY OF CONTRIBUTION  
14             RATES.—A statement of actuarial opinion,  
15             signed by a qualified health actuary, which sets  
16             forth a description of the extent to which con-  
17             tribution rates are adequate to provide for the  
18             payment of all obligations and the maintenance  
19             of required reserves under the plan for the 12-  
20             month period beginning with such date within  
21             such 120-day period, taking into account the  
22             expected coverage and experience of the plan. If  
23             the contribution rates are not fully adequate,  
24             the statement of actuarial opinion shall indicate

1 the extent to which the rates are inadequate  
2 and the changes needed to ensure adequacy.

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

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

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

23 “(c) FILING NOTICE OF CERTIFICATION WITH  
24 STATES.—A certification granted under this part to an  
25 association health plan shall not be effective unless written

1 notice of such certification is filed with the applicable  
2 State authority of each State in which at least 25 percent  
3 of the participants and beneficiaries under the plan are  
4 located. For purposes of this subsection, an individual  
5 shall be considered to be located in the State in which a  
6 known address of such individual is located or in which  
7 such individual is employed.

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

18       “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
19 SOCIATION HEALTH PLANS.—An association health plan  
20 certified under this part which provides benefit options in  
21 addition to health insurance coverage for such plan year  
22 shall meet the requirements of section 103 by filing an  
23 annual report under such section which shall include infor-  
24 mation described in subsection (b)(6) with respect to the  
25 plan year and, notwithstanding section 104(a)(1), shall be

1 filed with the applicable authority not later than 90 days  
2 after the close of the plan year (or on such later date as  
3 may be prescribed by the applicable authority). The appli-  
4 cable authority may require by regulation such interim re-  
5 ports as it considers appropriate.

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

19               “(1) are in the aggregate reasonably related to  
20 the experience of the plan and to reasonable expecta-  
21 tions; and

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



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

4 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
5 **MINATION.**

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

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

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

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

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

1 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
2 **NATION.**

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

1 tions. The board shall thereafter report to the applicable  
2 authority, in such form and frequency as the applicable  
3 authority may specify to the board, regarding corrective  
4 action taken by the board until the requirements of section  
5 806 are met.

6 “(b) MANDATORY TERMINATION.—In any case in  
7 which—

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

18 “(2) the applicable authority determines that  
19 there is a reasonable expectation that the plan will  
20 continue to fail to meet the requirements of section  
21 806,

22 the board of trustees of the plan shall, at the direction  
23 of the applicable authority, terminate the plan and, in the  
24 course of the termination, take such actions as the appli-  
25 cable authority may require, including satisfying any

1 claims referred to in section 806(a)(2)(B)(iii) and recov-  
2 ering for the plan any liability under subsection  
3 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
4 that the affairs of the plan will be, to the maximum extent  
5 possible, wound up in a manner which will result in timely  
6 provision of all benefits for which the plan is obligated.

7 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
8 **VENT ASSOCIATION HEALTH PLANS PRO-**  
9 **VIDING HEALTH BENEFITS IN ADDITION TO**  
10 **HEALTH INSURANCE COVERAGE.**

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

1 pants and beneficiaries or providers of medical care or to  
2 avoid any unreasonable deterioration of the financial con-  
3 dition of the plan. The trusteeship of such Secretary shall  
4 continue until the conditions described in the first sen-  
5 tence of this subsection are remedied or the plan is termi-  
6 nated.

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

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

13 “(2) to require the transfer of all (or any part)  
14 of the assets and records of the plan to the Sec-  
15 retary as trustee;

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

20 “(4) to require the sponsor, the plan adminis-  
21 trator, any participating employer, and any employee  
22 organization representing plan participants to fur-  
23 nish any information with respect to the plan which  
24 the Secretary as trustee may reasonably need in  
25 order to administer the plan;

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

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

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

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

16           “(9) to provide for the enrollment of plan par-  
17 ticipants and beneficiaries under appropriate cov-  
18 erage options; and

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

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

4               “(1) the sponsor and plan administrator;

5               “(2) each participant;

6               “(3) each participating employer; and

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

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

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

24       “(f) JURISDICTION OF COURT.—

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

24           “(2) VENUE.—An action under this section  
25          may be brought in the judicial district where the



1 sponsor or the plan administrator resides or does  
2 business or where any asset of the plan is situated.  
3 A district court in which such action is brought may  
4 issue process with respect to such action in any  
5 other judicial district.

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

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

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

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

22 “(1) such tax is computed by applying a rate to  
23 the amount of premiums or contributions, with re-  
24 spect to individuals covered under the plan who are  
25 residents of such State, which are received by the

1 plan from participating employers located in such  
2 State or from such individuals;

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

9 “(3) such tax is otherwise nondiscriminatory;  
10 and

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

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

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

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

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

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

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

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

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

23           “(7) INDIVIDUAL MARKET.—

24                   “(A) IN GENERAL.—The term ‘individual  
25 market’ means the market for health insurance

1 coverage offered to individuals other than in  
2 connection with a group health plan.

3 “(B) TREATMENT OF VERY SMALL  
4 GROUPS.—

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

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

21 “(8) PARTICIPATING EMPLOYER.—The term  
22 ‘participating employer’ means, in connection with  
23 an association health plan, any employer, if any indi-  
24 vidual who is an employee of such employer, a part-  
25 ner in such employer, or a self-employed individual

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

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

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

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

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

23 “(B) in the case of a sponsor with mem-  
24 bers which consist of associations, a person who

1 is a member of any such association and elects  
2 an affiliated status with the sponsor, or

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

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

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

19 “(b) RULES OF CONSTRUCTION.—

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

1       gram so determined to be such an employee welfare  
2       benefit plan—

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14           (B) in clause (ii)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“801. Association health plans.

“802. Certification of association health plans.

“803. Requirements relating to sponsors and boards of trustees.

“804. Participation and coverage requirements.

“805. Other requirements relating to plan documents, contribution rates, and  
 benefit options.

“806. Maintenance of reserves and provisions for solvency for plans providing  
 health benefits in addition to health insurance coverage.

“807. Requirements for application and related requirements.

“808. Notice requirements for voluntary termination.

“809. Corrective actions and mandatory termination.

“810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“811. State assessment authority.

“812. Definitions and rules of construction.”.

1 **SEC. 402. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 2 **PLOYER ARRANGEMENTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (1) by inserting “(a) IN GENERAL.—” before  
4 “In accordance”; and

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

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

13 **SEC. 404. COOPERATION BETWEEN FEDERAL AND STATE**  
14 **AUTHORITIES.**

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

18 “(d) CONSULTATION WITH STATES WITH RESPECT  
19 TO ASSOCIATION HEALTH PLANS.—

20 “(1) AGREEMENTS WITH STATES.—The Sec-  
21 retary shall consult with the State recognized under  
22 paragraph (2) with respect to an association health  
23 plan regarding the exercise of—

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

4           “(B) the Secretary’s authority to certify  
5           association health plans under part 8 in accord-  
6           ance with regulations of the Secretary applica-  
7           ble to certification under part 8.

8           “(2) RECOGNITION OF PRIMARY DOMICILE  
9           STATE.—In carrying out paragraph (1), the Sec-  
10          retary shall ensure that only one State will be recog-  
11          nized, with respect to any particular association  
12          health plan, as the State with which consultation is  
13          required. In carrying out this paragraph—

14               “(A) in the case of a plan which provides  
15               health insurance coverage (as defined in section  
16               812(a)(3)), such State shall be the State with  
17               which filing and approval of a policy type of-  
18               fered by the plan was initially obtained; and

19               “(B) in any other case, the Secretary shall  
20               take into account the places of residence of the  
21               participants and beneficiaries under the plan  
22               and the State in which the trust is main-  
23               tained.”.

1 **SEC. 405. EFFECTIVE DATE AND TRANSITIONAL AND**  
2 **OTHER RULES.**

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

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

11 (1) **IN GENERAL.**—In any case in which, as of  
12 the date of the enactment of this Act, an arrange-  
13 ment is maintained in a State for the purpose of  
14 providing benefits consisting of medical care for the  
15 employees and beneficiaries of its participating em-  
16 ployers, at least 200 participating employers make  
17 contributions to such arrangement, such arrange-  
18 ment has been in existence for at least 10 years, and  
19 such arrangement is licensed under the laws of one  
20 or more States to provide such benefits to its par-  
21 ticipating employers, upon the filing with the appli-  
22 cable authority (as defined in section 812(a)(5) of  
23 the Employee Retirement Income Security Act of  
24 1974 (as amended by this subtitle)) by the arrange-  
25 ment of an application for certification of the ar-

1        arrangement under part 8 of subtitle B of title I of  
2        such Act—

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

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

10               (C) the requirements of section 803(b) of  
11               such Act shall be deemed met, if the arrange-  
12               ment is operated by a board of directors  
13               which—

14                        (i) is elected by the participating em-  
15                        ployers, with each employer having one  
16                        vote; and

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

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

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

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

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

8           (2) DEFINITIONS.—For purposes of this sub-  
9           section, the terms “group health plan”, “medical  
10          care”, and “participating employer” shall have the  
11          meanings provided in section 812 of the Employee  
12          Retirement Income Security Act of 1974, except  
13          that the reference in subsection (a)(8) of such sec-  
14          tion to an “association health plan” shall be deemed  
15          a reference to an arrangement referred to in this  
16          subsection.

## 17       **TITLE V—MEDICAID REFORM**

### 18       **SEC. 501. INCREASING STATE FLEXIBILITY TO CONDUCT** 19       **MEDICAID WAIVERS.**

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

22           (1) by striking “1602, or 1902” and inserting  
23           “or 1602”; and

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

1           **TITLE VI—MISCELLANEOUS**  
2                           **PROVISIONS**

3   **SEC. 601. CERTAIN MEDICAL STOP-LOSS INSURANCE OB-**  
4                           **TAINED BY CERTAIN PLAN SPONSORS OF**  
5                           **GROUP HEALTH PLANS NOT INCLUDED**  
6                           **UNDER THE DEFINITION OF HEALTH INSUR-**  
7                           **ANCE COVERAGE.**

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

19           (b) ERISA.—Section 733(b)(1) of the Employee Re-  
20   tirement Income Security Act of 1974 (29 U.S.C.  
21   1191b(b)(1)) is amended by adding at the end the fol-  
22   lowing new sentence: “Such term shall not include a stop  
23   loss policy obtained by a self-insured health plan or a plan  
24   sponsor of a group health plan that self-insures the health  
25   risks of its plan participants to reimburse the plan or



1 sponsor for losses that the plan or sponsor incurs in pro-  
2 viding health or medical benefits to such plan participants  
3 in excess of a predetermined level set forth in the stop  
4 loss policy obtained by such plan or sponsor.”.

5 (c) IRC.—Section 9832(b)(1)(A) of the Internal Rev-  
6 enue Code of 1986 is amended by adding at the end the  
7 following new sentence: “Such term shall not include a  
8 stop loss policy obtained by a self-insured health plan or  
9 a plan sponsor of a group health plan that self-insures  
10 the health risks of its plan participants to reimburse the  
11 plan or sponsor for losses that the plan or sponsor incurs  
12 in providing health or medical benefits to such plan par-  
13 ticipants in excess of a predetermined level set forth in  
14 the stop loss policy obtained by such plan or sponsor.”.

15 **SEC. 602. RESTORING THE APPLICATION OF ANTITRUST**  
16 **LAWS TO HEALTH SECTOR INSURERS.**

17 (a) AMENDMENT TO MCCARRAN-FERGUSON ACT.—  
18 Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013),  
19 commonly known as the McCarran-Ferguson Act, is  
20 amended by adding at the end the following:

21 “(c)(1) Nothing contained in this Act shall modify,  
22 impair, or supersede the operation of any of the antitrust  
23 laws with respect to the business of health insurance (in-  
24 cluding the business of dental insurance). For purposes  
25 of the preceding sentence, the term ‘antitrust laws’ has

1 the meaning given it in subsection (a) of the first section  
2 of the Clayton Act, except that such term includes section  
3 5 of the Federal Trade Commission Act to the extent that  
4 such section 5 applies to unfair methods of competition.

5 “(2) For purposes of paragraph (1), the term  
6 ‘business of health insurance (including the business  
7 of dental insurance)’ does not include—

8 “(A) the business of life insurance (includ-  
9 ing annuities); or

10 “(B) the business of property or casualty  
11 insurance, including but not limited to, any in-  
12 surance or benefits defined as ‘excepted bene-  
13 fits’ under paragraph (1), subparagraph (B) or  
14 (C) of paragraph (2), or paragraph (3) of sec-  
15 tion 9832(c) of the Internal Revenue Code of  
16 1986 (26 U.S.C. 9832(c)) whether offered sepa-  
17 rately or in combination with insurance or bene-  
18 fits described in paragraph (2)(A) of such sec-  
19 tion.”.

20 (b) RELATED PROVISION.—For purposes of section  
21 5 of the Federal Trade Commission Act (15 U.S.C. 45)  
22 to the extent such section applies to unfair methods of  
23 competition, section 3(c) of the McCarran-Ferguson Act  
24 shall apply with respect to the business of health insurance  
25 without regard to whether such business is carried on for

1 profit, notwithstanding the definition of “Corporation”  
2 contained in section 4 of the Federal Trade Commission  
3 Act.

○