

1 a border-adjustable business consumption tax in its
2 place; to provide a new method of business taxation
3 that will level the playing field for United States
4 businesses to compete with foreign businesses and
5 will promote sustained economic growth, investment
6 and job creation in America.

7 (7) BUDGET PROCESS.—To keep total spending
8 of the Government under control, a limit on total
9 outlays as a percentage of the gross domestic
10 produce is established; and enforced by automatic
11 spending controls if it is exceeded.

12 **TITLE I—HEALTH CARE REFORM**

13 **Subtitle A—Tax Changes**

14 **SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE**

15 **COVERAGE.**

16 (a) IN GENERAL.—Subpart C of part IV of sub-
17 chapter A of chapter 1 of the Internal Revenue Code of
18 1986 (relating to refundable credits) is amended by redес-
19 ignating section 36 as section 37 and by inserting after
20 section 35 the following new section:

21 **“SEC. 36. QUALIFIED HEALTH INSURANCE CREDIT.**

22 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
23 dividual, there shall be allowed as a credit against the tax
24 imposed by this chapter for the taxable year the sum of
25 the monthly limitations determined under subsection (b)

1 for the taxpayer and the taxpayer's spouse and depend-
2 ents.

3 “(b) MONTHLY LIMITATION.—

4 “(1) IN GENERAL.—The monthly limitation for
5 each month during the taxable year for an eligible
6 individual is $\frac{1}{12}$ th of—

7 “(A) the applicable adult amount, in the
8 case that the eligible individual is the taxpayer
9 or the taxpayer's spouse,

10 “(B) the applicable adult amount, in the
11 case that the eligible individual is an adult de-
12 pendent, and

13 “(C) the applicable child amount, in the
14 case that the eligible individual is a child de-
15 pendent.

16 “(2) LIMITATION ON AGGREGATE AMOUNT.—
17 Notwithstanding paragraph (1), the aggregate
18 monthly limitations for the taxpayer and the tax-
19 payer's spouse and dependents for any month shall
20 not exceed $\frac{1}{12}$ th of the applicable aggregate amount.

21 “(3) NO CREDIT FOR INELIGIBLE MONTHS.—
22 With respect to any individual, the monthly limita-
23 tion shall be zero for any month for which such indi-
24 vidual is not an eligible individual.

1 “(c) APPLICABLE AMOUNTS.—For purposes of this
2 section—

3 “(1) APPLICABLE ADULT AMOUNT.—The term
4 ‘applicable adult amount’ means \$2,500.

5 “(2) APPLICABLE CHILD AMOUNT.—The term
6 ‘applicable child amount’ means \$1,000.

7 “(3) APPLICABLE AGGREGATE AMOUNT.—The
8 term ‘applicable aggregate amount’ means \$5,000.

9 “(d) ELIGIBLE INDIVIDUAL.—For purposes of this
10 section—

11 “(1) IN GENERAL.—The term ‘eligible indi-
12 vidual’ means, with respect to any month, an indi-
13 vidual who—

14 “(A) is the taxpayer, the taxpayer’s
15 spouse, or the taxpayer’s dependent, and

16 “(B) is covered under qualified health in-
17 surance as of the 1st day of such month.

18 “(2) COVERAGE UNDER MEDICARE, MEDICAID,
19 SCHIP, MILITARY COVERAGE.—The term ‘eligible in-
20 dividual’ shall not include any individual for a month
21 if, as of the first day of such month, such individual
22 is—

23 “(A) entitled to benefits under part A of
24 title XVIII of the Social Security Act or en-
25 rolled under part B of such title, and the indi-

1 vidual is not a participant or beneficiary in a
2 group health plan or large group health plan
3 that is a primary plan (as defined in section
4 1862(b)(2)(A) of such Act),

5 “(B) in the case of a State that has not
6 made the election described in section
7 1939(a)(1)(B) of the Social Security Act, en-
8 rolled in the program under title XIX of such
9 Act (other than under section 1928 of such
10 Act), or

11 “(C) entitled to benefits under chapter 55
12 of title 10, United States Code.

13 “(3) IDENTIFICATION REQUIREMENTS.—The
14 term ‘eligible individual’ shall not include any indi-
15 vidual for any month unless the policy number asso-
16 ciated with the qualified refund eligible health insur-
17 ance and the TIN of each eligible individual covered
18 under such health insurance for such month are in-
19 cluded on the return of tax for the taxable year in
20 which such month occurs.

21 “(4) PRISONERS.—The term ‘eligible individual’
22 shall not include any individual for a month if, as
23 of the first day of such month, such individual is im-
24 prisoned under Federal, State, or local authority.

1 “(5) ALIENS.—The term ‘eligible individual’
2 shall not include any alien individual for a month if,
3 as of the first day of such month, such individual is
4 not a lawful permanent resident of the United
5 States.

6 “(e) QUALIFIED HEALTH INSURANCE.—For pur-
7 poses of this section, the term ‘qualified health insurance’
8 means any insurance constituting medical care which (as
9 determined under regulations prescribed by the Secretary)
10 provides coverage for inpatient and outpatient care, emer-
11 gency benefits, and physician care. Such term does not
12 include any insurance substantially all of the coverage of
13 which is coverage described in section 223(c)(1)(B).

14 “(f) OTHER DEFINITIONS.—For purposes of this sec-
15 tion—

16 “(1) DEPENDENT.—The term ‘dependent’ has
17 the meaning given such term by section 152 (deter-
18 mined without regard to subsections (b)(1), (b)(2),
19 and (d)(1)(B) thereof). An individual who is a child
20 to whom section 152(e) applies shall be treated as
21 a dependent of the custodial parent for a coverage
22 month unless the custodial and noncustodial parent
23 agree otherwise.

24 “(2) ADULT.—The term ‘adult’ means an indi-
25 vidual who is not a child.

1 “(3) CHILD.—The term ‘child’ means a quali-
2 fying child (as defined in section 152(e)).

3 “(g) SPECIAL RULES.—

4 “(1) COORDINATION WITH MEDICAL DEDUC-
5 TION, ETC.—Any amount paid by a taxpayer for in-
6 surance to which subsection (a) applies shall not be
7 taken into account in computing the amount allow-
8 able to the taxpayer as a credit under section 35 or
9 as a deduction under section 213(a).

10 “(2) MEDICAL AND HEALTH SAVINGS AC-
11 COUNTS.—The credit allowed under subsection (a)
12 for any taxable year shall be reduced by the aggre-
13 gate amount distributed from Archer MSAs (as de-
14 fined in section 220(d)) and health savings accounts
15 (as defined in section 223(d)) which are excludable
16 from gross income for such taxable years by reason
17 of being used to pay premiums for coverage of an
18 eligible individual (as defined in section 25E(e))
19 under qualified health insurance (as defined in sec-
20 tion 25E(f)) for any month.

21 “(3) DENIAL OF CREDIT TO DEPENDENTS.—No
22 credit shall be allowed under this section to any indi-
23 vidual with respect to whom a deduction under sec-
24 tion 151 is allowable to another taxpayer for a tax-

1 able year beginning in the calendar year in which
2 such individual's taxable year begins.

3 “(4) MARRIED COUPLES MUST FILE JOINT RE-
4 TURN.—

5 “(A) IN GENERAL.—If the taxpayer is
6 married at the close of the taxable year, the
7 credit shall be allowed under subsection (a) only
8 if the taxpayer and his spouse file a joint return
9 for the taxable year.

10 “(B) MARITAL STATUS; CERTAIN MARRIED
11 INDIVIDUALS LIVING APART.—Rules similar to
12 the rules of paragraphs (3) and (4) of section
13 21(e) shall apply for purposes of this para-
14 graph.

15 “(5) VERIFICATION OF COVERAGE, ETC.—No
16 credit shall be allowed under this section with re-
17 spect to any individual unless such individual's cov-
18 erage (and such related information as the Secretary
19 may require) is verified in such manner as the Sec-
20 retary may prescribe.

21 “(6) INSURANCE WHICH COVERS OTHER INDI-
22 VIDUALS; TREATMENT OF PAYMENTS.—Rules similar
23 to the rules of paragraphs (7) and (8) of section
24 35(g) shall apply for purposes of this section.

25 “(h) COORDINATION WITH ADVANCE PAYMENTS.—

1 “(1) REDUCTION IN CREDIT FOR ADVANCE PAY-
2 MENTS.—With respect to any taxable year, the
3 amount which would (but for this subsection) be al-
4 lowed as a credit to the taxpayer under subsection
5 (a) shall be reduced (but not below zero) by the ag-
6 gregate amount paid on behalf of such taxpayer
7 under section 7527A for months beginning in such
8 taxable year.

9 “(2) RECAPTURE OF EXCESS ADVANCE PAY-
10 MENTS.—If the aggregate amount paid on behalf of
11 the taxpayer under section 7527A for months begin-
12 ning in the taxable year exceeds the sum of the
13 monthly limitations determined under subsection (b)
14 for the taxpayer and the taxpayer’s spouse and de-
15 pendents for such months, then the tax imposed by
16 this chapter for such taxable year shall be increased
17 by the sum of—

18 “(A) such excess, plus

19 “(B) interest on such excess determined at
20 the underpayment rate established under sec-
21 tion 6621 for the period from the date of the
22 payment under section 7527A to the date such
23 excess is paid.

24 For purposes of subparagraph (B), an equal part of
25 the aggregate amount of the excess shall be deemed

1 to be attributable to payments made under section
2 7527A on the first day of each month beginning in
3 such taxable year, unless the taxpayer establishes
4 the date on which each such payment giving rise to
5 such excess occurred, in which case subparagraph
6 (B) shall be applied with respect to each date so es-
7 tablished.

8 “(i) ANNUAL INFLATION ADJUSTMENT.—In the case
9 of any taxable year beginning in a calendar year after
10 2009, each of the dollar amounts contained in subsection
11 (c) shall be annually increased by the annual inflation ad-
12 justment determined under subparagraph (B) section
13 1809(c)(2) of the Social Security Act for such calendar
14 year. Any adjustment under the preceding sentence shall
15 be rounded in the manner described in subparagraph (A)
16 of such section.”.

17 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 77
18 (relating to miscellaneous provisions) of such Code is
19 amended by inserting after section 7527 the following new
20 section:

21 **“SEC. 7527A. ADVANCE PAYMENT OF QUALIFIED HEALTH**
22 **INSURANCE CREDIT.**

23 “(a) IN GENERAL.—The Secretary shall establish a
24 program for making payments on behalf of individuals to

1 providers of qualified health insurance (as defined in sec-
2 tion 36(f)) for such individuals.

3 “(b) LIMITATION.—The Secretary may make pay-
4 ments under subsection (a) only to the extent that the Sec-
5 retary determines that the amount of such payments made
6 on behalf of any taxpayer for any month does not exceed
7 the sum of the monthly limitations determined under sec-
8 tion 36 for the taxpayer and taxpayer’s spouse and de-
9 pendants for such month.”.

10 (c) INFORMATION REPORTING.—

11 (1) IN GENERAL.—Subpart B of part III of
12 subchapter A of chapter 61 of such Code (relating
13 to information concerning transactions with other
14 persons) is amended by inserting after section
15 6050V the following new section:

16 **“SEC. 6050W. RETURNS RELATING TO QUALIFIED HEALTH**
17 **INSURANCE CREDIT.**

18 “(a) REQUIREMENT OF REPORTING.—Every person
19 who is entitled to receive payments for any month of any
20 calendar year under section 7527A (relating to advance
21 payment of qualified health insurance credit) with respect
22 to any individual shall, at such time as the Secretary may
23 prescribe, make the return described in subsection (b) with
24 respect to each such individual.

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

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

5 “(2) contains, with respect to each individual
6 referred to in subsection (a)—

7 “(A) the name, address, and TIN of each
8 such individual,

9 “(B) the months for which amounts pay-
10 ments under section 7527A were received,

11 “(C) the amount of each such payment,

12 “(D) the type of insurance coverage pro-
13 vide by such person with respect to such indi-
14 vidual and the policy number associated with
15 such coverage,

16 “(E) the name, address, and TIN of the
17 spouse and each dependent covered under such
18 coverage, and

19 “(F) such other information as the Sec-
20 retary may prescribe.

21 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
22 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
23 QUIRED.—Every person required to make a return under
24 subsection (a) shall furnish to each individual whose name

1 is required to be set forth in such return a written state-
2 ment showing—

3 “(1) the name and address of the person re-
4 quired to make such return and the phone number
5 of the information contact for such person, and

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

8 The written statement required under the preceding sen-
9 tence shall be furnished on or before January 31 of the
10 year following the calendar year for which the return
11 under subsection (a) is required to be made.

12 “(d) RETURNS WHICH WOULD BE REQUIRED TO BE
13 MADE BY 2 OR MORE PERSONS.—Except to the extent
14 provided in regulations prescribed by the Secretary, in the
15 case of any amount received by any person on behalf of
16 another person, only the person first receiving such
17 amount shall be required to make the return under sub-
18 section (a).”.

19 (2) ASSESSABLE PENALTIES.—

20 (A) Subparagraph (B) of section
21 6724(d)(1) (relating to definitions) of such
22 Code is amended by redesignating clauses (xv)
23 through (xxi) as clauses (xvi) through (xxii), re-
24 spectively, and by inserting after clause (xiv)
25 the following new clause:

1 “(xv) section 6050W (relating to re-
2 turns relating to qualified health insurance
3 credit),”.

4 (B) Paragraph (2) of section 6724(d) of
5 such Code is amended by striking the period at
6 the end of subparagraph (CC) and inserting “,
7 or” and by inserting after subparagraph (CC)
8 the following new subparagraph:

9 “(DD) section 6050W (relating to returns
10 relating to qualified health insurance credit).”.

11 (d) CONFORMING AMENDMENTS.—

12 (1) Paragraph (2) of section 1324(b) of title
13 31, United States Code, is amended by inserting “or
14 36” after “section 35”.

15 (2) The table of sections for subpart C of part
16 IV of subchapter A of chapter 1 of the Internal Rev-
17 enue Code of 1986 is amended by redesignating the
18 item relating to section 36 as an item relating to
19 section 37 and by inserting after the item relating
20 to section 35 the following new item:

“Sec. 36. Qualified health insurance credit.”.

21 (3) The table of sections for chapter 77 of such
22 Code is amended by inserting after the item relating
23 to section 7527 the following new item:

“Sec. 7527A. Advance payment of qualified health insurance credit.”.

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

“Sec. 6050W. Returns relating to qualified health insurance credit.”.

5 (e) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to taxable years beginning after
7 December 31, 2008.

8 **SEC. 102. CHANGES TO EXISTING TAX PREFERENCES FOR**
9 **MEDICAL COVERAGE, ETC., FOR INDIVIDUALS**
10 **ELIGIBLE FOR QUALIFIED HEALTH INSUR-**
11 **ANCE CREDIT.**

12 (a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER
13 TO ACCIDENT AND HEALTH PLANS.—

14 (1) IN GENERAL.—Section 106 of the Internal
15 Revenue Code of 1986 (relating to contributions by
16 employer to accident and health plans) is amended
17 by adding at the end the following new subsection:

18 “(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE
19 FOR QUALIFIED HEALTH INSURANCE CREDIT.—Sub-
20 section (a) shall not apply with respect to any employer-
21 provided coverage under an accident or health plan for any
22 individual for any month unless such individual is de-
23 scribed in paragraph (2) or (5) of section 36(e) for such
24 month. The amount includible in gross income by reason

1 of this subsection shall be determined under rules similar
2 to the rules of section 4980B(f)(4).”.

3 (2) CONFORMING AMENDMENTS.—

4 (A) Section 106(b)(1) of such Code is
5 amended—

6 (i) by inserting “gross income does
7 not include” before “amounts contrib-
8 uted”, and

9 (ii) by striking “shall be treated as
10 employer-provided coverage for medical ex-
11 penses under an accident or health plan”.

12 (B) Section 106(d)(1) of such Code is
13 amended—

14 (i) by inserting “gross income does
15 not include” before “amounts contrib-
16 uted”, and

17 (ii) by striking “shall be treated as
18 employer-provided coverage for medical ex-
19 penses under an accident or health plan”.

20 (b) AMOUNTS RECEIVED UNDER ACCIDENT AND
21 HEALTH PLANS.—

22 (1) IN GENERAL.—Section 105 of such Code
23 (relating to amounts received under accident and
24 health plans) is amended by adding at the end the
25 following new subsection:

1 “(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE
2 FOR QUALIFIED HEALTH INSURANCE CREDIT.—Sub-
3 section (b) shall not apply with respect to any employer-
4 provided coverage under an accident or health plan for any
5 individual for any month unless such individual is de-
6 scribed in paragraph (2) or (5) of section 36(e) for such
7 month.”.

8 (c) SPECIAL RULES FOR HEALTH INSURANCE COSTS
9 OF SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of
10 section 162 of such Code (relating to special rules for
11 health insurance costs of self-employed individuals) is
12 amended by adding at the end the following new para-
13 graph:

14 “(6) NO DEDUCTION TO INDIVIDUALS ELIGIBLE
15 FOR QUALIFIED HEALTH INSURANCE.—Paragraph
16 (1) shall not apply for any individual for any month
17 unless such individual is described in paragraph (2)
18 or (5) of section 36(e) for such month.”.

19 (d) EARNED INCOME CREDIT UNAFFECTED BY RE-
20 PEATED EXCLUSIONS.—Subparagraph (B) of section
21 32(c)(2) of such Code is amended by redesignating clauses
22 (v) and (vi) as clauses (vi) and (vii), respectively, and by
23 inserting after clause (iv) the following new clause:

1 “(v) the earned income of an indi-
2 vidual shall be computed without regard to
3 sections 105(f) and 106(f),”.

4 (e) MODIFICATION OF DEDUCTION FOR MEDICAL
5 EXPENSES.—Subsection (d) of section 213 of such Code
6 is amended by adding at the end the following new para-
7 graph:

8 “(12) PREMIUMS FOR QUALIFIED HEALTH IN-
9 SURANCE.—The term ‘medical care’ does not include
10 any amount paid as a premium for coverage of an
11 eligible individual (as defined in section 36(e)) under
12 qualified health insurance (as defined in section
13 36(f)) for any month.”.

14 (f) REPORTING REQUIREMENT.—Subsection (a) of
15 section 6051 of such Code is amended by striking “and”
16 at the end of paragraph (12), by striking the period at
17 the end of paragraph (13) and inserting “and”, and by
18 inserting after paragraph (13) the following new para-
19 graph:

20 “(14) the total amount of employer-provided
21 coverage under an accident or health plan which is
22 includible in gross income by reason of sections
23 105(f) and 106(f).”.

24 (g) RETIRED PUBLIC SAFETY OFFICERS.—Section
25 402(l)(4)(D) of such Code is amended by adding at the

1 end the following: “Such term shall not include any pre-
2 mium for coverage by an accident or health insurance plan
3 for any month unless such individual is described in para-
4 graph (2) or (5) of section 36(e) for such month.”.

5 (h) EMPLOYER DEDUCTION AS TRADE OR BUSINESS
6 EXPENSE UNAFFECTED.—For the allowance of a deduc-
7 tion for amounts paid or incurred by an employer for em-
8 ployee health benefits, see section 162 of the Internal Rev-
9 enue Code of 1986 (relating to trade or business ex-
10 penses).

11 (i) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to taxable years beginning after
13 December 31, 2008.

14 **Subtitle B—Health Plan Choice;**
15 **Small Business Health Fairness**

16 **SEC. 111. COOPERATIVE GOVERNING OF INDIVIDUAL**
17 **HEALTH INSURANCE COVERAGE.**

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

21 **“PART D—COOPERATIVE GOVERNING OF**
22 **INDIVIDUAL HEALTH INSURANCE COVERAGE**
23 **“SEC. 2795. DEFINITIONS.**

24 “In this part:

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

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

24 “(3) HEALTH INSURANCE ISSUER.—The term
25 ‘health insurance issuer’ has the meaning given such

1 term in section 2791(b)(2), except that such an
2 issuer must be licensed in the primary State and be
3 qualified to sell individual health insurance coverage
4 in that State.

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

10 “(5) APPLICABLE STATE AUTHORITY.—The
11 term ‘applicable State authority’ means, with respect
12 to a health insurance issuer in a State, the State in-
13 surance commissioner or official or officials des-
14 ignated by the State to enforce the requirements of
15 this title for the State with respect to the issuer.

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

21 “(A) to meet obligations to policyholders
22 with respect to known claims and reasonably
23 anticipated claims; or

24 “(B) to pay other obligations in the normal
25 course of business.

1 “(7) COVERED LAWS.—

2 “(A) IN GENERAL.—The term ‘covered
3 laws’ means the laws, rules, regulations, agree-
4 ments, and orders governing the insurance busi-
5 ness pertaining to—

6 “(i) individual health insurance cov-
7 erage issued by a health insurance issuer;

8 “(ii) the offer, sale, rating (including
9 medical underwriting), renewal, and
10 issuance of individual health insurance cov-
11 erage to an individual;

12 “(iii) the provision to an individual in
13 relation to individual health insurance cov-
14 erage of health care and insurance related
15 services;

16 “(iv) the provision to an individual in
17 relation to individual health insurance cov-
18 erage of management, operations, and in-
19 vestment activities of a health insurance
20 issuer; and

21 “(v) the provision to an individual in
22 relation to individual health insurance cov-
23 erage of loss control and claims adminis-
24 tration for a health insurance issuer with

1 respect to liability for which the issuer pro-
2 vides insurance.

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

10 “(8) STATE.—The term ‘State’ means the 50
11 States and includes the District of Columbia, Puerto
12 Rico, the Virgin Islands, Guam, American Samoa,
13 and the Northern Mariana Islands.

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

17 “(A) Knowingly misrepresenting to claim-
18 ants and insured individuals relevant facts or
19 policy provisions relating to coverage at issue.

20 “(B) Failing to acknowledge with reason-
21 able promptness pertinent communications with
22 respect to claims arising under policies.

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

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

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

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

10 “(G) A pattern or practice of compelling
11 insured individuals or their beneficiaries to in-
12 stitute suits to recover amounts due under its
13 policies by offering substantially less than the
14 amounts ultimately recovered in suits brought
15 by them.

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

23 “(I) Attempting to settle or settling claims
24 on the basis of an application that was materi-

1 ally altered without notice to, or knowledge or
2 consent of, the insured.

3 “(J) Failing to provide forms necessary to
4 present claims within 15 calendar days of a re-
5 quests with reasonable explanations regarding
6 their use.

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

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

15 “(A) Presenting, causing to be presented
16 or preparing with knowledge or belief that it
17 will be presented to or by an insurer, a rein-
18 surer, broker or its agent, false information as
19 part of, in support of or concerning a fact ma-
20 terial to one or more of the following:

21 “(i) An application for the issuance or
22 renewal of an insurance policy or reinsur-
23 ance contract.

24 “(ii) The rating of an insurance policy
25 or reinsurance contract.

1 “(iii) A claim for payment or benefit
2 pursuant to an insurance policy or reinsur-
3 ance contract.

4 “(iv) Premiums paid on an insurance
5 policy or reinsurance contract.

6 “(v) Payments made in accordance
7 with the terms of an insurance policy or
8 reinsurance contract.

9 “(vi) A document filed with the com-
10 missioner or the chief insurance regulatory
11 official of another jurisdiction.

12 “(vii) The financial condition of an in-
13 surer or reinsurer.

14 “(viii) The formation, acquisition,
15 merger, reconsolidation, dissolution or
16 withdrawal from one or more lines of in-
17 surance or reinsurance in all or part of a
18 State by an insurer or reinsurer.

19 “(ix) The issuance of written evidence
20 of insurance.

21 “(x) The reinstatement of an insur-
22 ance policy.

23 “(B) Solicitation or acceptance of new or
24 renewal insurance risks on behalf of an insurer
25 reinsurer or other person engaged in the busi-

1 ness of insurance by a person who knows or
2 should know that the insurer or other person
3 responsible for the risk is insolvent at the time
4 of the transaction.

5 “(C) Transaction of the business of insur-
6 ance in violation of laws requiring a license, cer-
7 tificate of authority or other legal authority for
8 the transaction of the business of insurance.

9 “(D) Attempt to commit, aiding or abet-
10 ting in the commission of, or conspiracy to com-
11 mit the acts or omissions specified in this para-
12 graph.

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

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

20 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
21 ONDARY STATE.—Except as provided in this section, a
22 health insurance issuer with respect to its offer, sale, rat-
23 ing (including medical underwriting), renewal, and
24 issuance of individual health insurance coverage in any
25 secondary State is exempt from any covered laws of the

1 secondary State (and any rules, regulations, agreements,
2 or orders sought or issued by such State under or related
3 to such covered laws) to the extent that such laws would—

4 “(1) make unlawful, or regulate, directly or in-
5 directly, the operation of the health insurance issuer
6 operating in the secondary State, except that any
7 secondary State may require such an issuer—

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

13 “(B) to register with and designate the
14 State insurance commissioner as its agent solely
15 for the purpose of receiving service of legal doc-
16 uments or process;

17 “(C) to submit to an examination of its fi-
18 nancial condition by the State insurance com-
19 missioner in any State in which the issuer is
20 doing business to determine the issuer’s finan-
21 cial condition, if—

22 “(i) the State insurance commissioner
23 of the primary State has not done an ex-
24 amination within the period recommended

1 by the National Association of Insurance
2 Commissioners; and

3 “(ii) any such examination is con-
4 ducted in accordance with the examiners’
5 handbook of the National Association of
6 Insurance Commissioners and is coordi-
7 nated to avoid unjustified duplication and
8 unjustified repetition;

9 “(D) to comply with a lawful order
10 issued—

11 “(i) in a delinquency proceeding com-
12 menced by the State insurance commis-
13 sioner if there has been a finding of finan-
14 cial impairment under subparagraph (C);
15 or

16 “(ii) in a voluntary dissolution pro-
17 ceeding;

18 “(E) to comply with an injunction issued
19 by a court of competent jurisdiction, upon a pe-
20 tition by the State insurance commissioner al-
21 leging that the issuer is in hazardous financial
22 condition;

23 “(F) to participate, on a nondiscriminatory
24 basis, in any insurance insolvency guaranty as-
25 sociation or similar association to which a

1 health insurance issuer in the State is required
2 to belong;

3 “(G) to comply with any State law regard-
4 ing fraud and abuse (as defined in section
5 2795(10)), except that if the State seeks an in-
6 junction regarding the conduct described in this
7 subparagraph, such injunction must be obtained
8 from a court of competent jurisdiction;

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

12 “(I) to comply with the applicable require-
13 ments for independent review under section
14 2798 with respect to coverage offered in the
15 State;

16 “(2) require any individual health insurance
17 coverage issued by the issuer to be countersigned by
18 an insurance agent or broker residing in that Sec-
19 ondary State; or

20 “(3) otherwise discriminate against the issuer
21 issuing insurance in both the primary State and in
22 any secondary State.

23 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
24 health insurance issuer shall provide the following notice,
25 in 12-point bold type, in any insurance coverage offered

1 in a secondary State under this part by such a health in-
2 surance issuer and at renewal of the policy, with the 5
3 blank spaces therein being appropriately filled with the
4 name of the health insurance issuer, the name of primary
5 State, the name of the secondary State, the name of the
6 secondary State, and the name of the secondary State, re-
7 spectively, for the coverage concerned:

8 **“Notice**

9 **“This policy is issued by _____ and is**
10 **governed by the laws and regulations of the**
11 **State of _____, and it has met all the laws**
12 **of that State as determined by that State’s De-**
13 **partment of Insurance. This policy may be**
14 **less expensive than others because it is not**
15 **subject to all of the insurance laws and regu-**
16 **lations of the State of _____, including**
17 **coverage of some services or benefits man-**
18 **dated by the law of the State of _____. Ad-**
19 **ditionally, this policy is not subject to all of**
20 **the consumer protection laws or restrictions**
21 **on rate changes of the State of _____. As**
22 **with all insurance products, before pur-**
23 **chasing this policy, you should carefully re-**
24 **view the policy and determine what health**
25 **care services the policy covers and what bene-**

1 **fits it provides, including any exclusions, limi-**
2 **tations, or conditions for such services or ben-**
3 **efits.’.**

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

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

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

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

21 “(2) CONSTRUCTION.—Nothing in paragraph
22 (1) shall be construed to prohibit a health insurance
23 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 subparagraph (A) are not met with respect to the ei-
18 ther of such States, the issuer provides an inde-
19 pendent review mechanism substantially identical (as
20 determined 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 1 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 1
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-in-
9 sured;

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 (d) SEVERABILITY.—If any provision of this title or
2 the application of such provision to any person or cir-
3 cumstance is held to be unconstitutional, the remainder
4 of this title and the application of the provisions of such
5 to any other person or circumstance shall not be affected.

6 **SEC. 112. SMALL BUSINESS HEALTH FAIRNESS.**

7 (a) RULES GOVERNING ASSOCIATION HEALTH
8 PLANS.—

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

13 **“PART 8—RULES GOVERNING ASSOCIATION**
14 **HEALTH PLANS**

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

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

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

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

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

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

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

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

1 shall be deemed to be a sponsor described in this sub-
2 section.

3 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
4 **PLANS.**

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

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

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

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

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

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

20 “(1) a plan which offered such coverage on the
21 date of the enactment of this part,

22 “(2) a plan under which the sponsor does not
23 restrict membership to one or more trades and busi-
24 nesses or industries and whose eligible participating

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

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

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

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

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

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

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

26 “(A) BOARD MEMBERSHIP.—

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

9 “(ii) LIMITATION.—

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

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

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

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

12 “(iii) CERTAIN PLANS EXCLUDED.—
13 Clause (I) shall not apply to an association
14 health plan which is in existence on the
15 date of the enactment of this part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 “(1) \$500,000, or

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(3) ASSOCIATION HEALTH PLAN FUND.—

11 “(A) IN GENERAL.—There is established
12 on the books of the Treasury a fund to be
13 known as the ‘Association Health Plan Fund’.
14 The Fund shall be available for making pay-
15 ments pursuant to paragraph (2). The Fund
16 shall be credited with payments received pursu-
17 ant to paragraph (1)(A), penalties received pur-
18 suant to paragraph (1)(B); and earnings on in-
19 vestments of amounts of the Fund under sub-
20 paragraph (B).

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

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

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

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

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

15 “(B) which is guaranteed renewable; and

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

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

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

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

6 “(B) which is guaranteed renewable; and

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

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

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

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

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

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

7 “(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

21 “(A) a representative of the National Asso-
22 ciation of Insurance Commissioners;

23 “(B) a representative of the American
24 Academy of Actuaries;

1 “(c) a representative of the State govern-
2 ments, or their interests;

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

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

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

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

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

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

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

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

5 “(A) the sponsor; and

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

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

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

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

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

1 plan and contract administrators and other service
2 providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 Actions required under this section shall be taken in such
24 form and manner as may be prescribed by the applicable
25 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 actuary engaged by the plan, and such actuary
16 shall, not later than the end of the next following month,
17 make such recommendations to the board for corrective
18 action as the actuary determines necessary to ensure com-
19 pliance with section 806. Not later than 30 days after re-
20 ceiving from the actuary recommendations for corrective
21 actions, the board shall notify the applicable authority (in
22 such form and manner as the applicable authority may
23 prescribe by regulation) of such recommendations of the
24 actuary for corrective action, together with a description
25 of the actions (if any) that the board has taken or plans
26 to take in response to such recommendations. The board

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

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

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

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

21 the board of trustees of the plan shall, at the direction
22 of the applicable authority, terminate the plan and, in the
23 course of the termination, take such actions as the appli-
24 cable authority may require, including satisfying any
25 claims referred to in section 806(a)(2)(B)(iii) and recov-

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

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

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

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

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

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

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

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

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

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 ACTUARY.—The term ‘quali-
15 fied actuary’ means an individual who is a member
16 of the American Academy of Actuaries.

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

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

22 “(B) in the case of a sponsor with mem-
23 bers which consist of associations, a person who
24 is a member of any such association and elects
25 an affiliated status with the sponsor, or

1 “(C) in the case of an association health
2 plan in existence on the date of the enactment
3 of this part, a person eligible to be a member
4 of the sponsor or one of its member associa-
5 tions.

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

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

17 “(b) RULES OF CONSTRUCTION.—

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

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

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

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

1 (2) CONFORMING AMENDMENTS TO PREEMP-
2 TION RULES.—

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

6 “(E) The preceding subparagraphs of this paragraph
7 do not apply with respect to any State law in the case
8 of an association health plan which is certified under part
9 8.”.

10 (B) Section 514 of such Act (29 U.S.C.
11 1144) is amended—

12 (i) in subsection (b)(4), by striking
13 “Subsection (a)” and inserting “Sub-
14 sections (a) and (d)”;

15 (ii) in subsection (b)(5), by striking
16 “subsection (a)” in subparagraph (A) and
17 inserting “subsection (a) of this section
18 and subsections (a)(2)(B) and (b) of sec-
19 tion 805”, and by striking “subsection (a)”
20 in subparagraph (B) and inserting “sub-
21 section (a) of this section or subsection
22 (a)(2)(B) or (b) of section 805”;

23 (iii) by redesignating subsection (d) as
24 subsection (e); and

1 (iv) by inserting after subsection (c)
2 the following new subsection:

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

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

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

24 “(B) In any case in which health insurance cov-
25 erage of any policy type is offered in a State under

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

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

16 “(A) providing solvency standards or similar
17 standards regarding the adequacy of insurer capital,
18 surplus, reserves, or contributions, or

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

20 “(4) For additional provisions relating to association
21 health plans, see subsections (a)(2)(B) and (b) of section
22 805.

23 “(5) For purposes of this subsection, the term ‘asso-
24 ciation health plan’ has the meaning provided in section
25 801(a), and the terms ‘health insurance coverage’, ‘par-

1 ticipating employer’, and ‘health insurance issuer’ have
2 the meanings provided such terms in section 812, respec-
3 tively.”.

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

6 (i) in clause (I)(II), by striking “and”
7 at the end;

8 (ii) in clause (ii), by inserting “and
9 which does not provide medical care (with-
10 in the meaning of section 733(a)(2)),”
11 after “arrangement,”, and by striking
12 “title.” and inserting “title, and”; and

13 (iii) by adding at the end the fol-
14 lowing new clause:

15 “(iii) subject to subparagraph (E), in the case
16 of any other employee welfare benefit plan which is
17 a multiple employer welfare arrangement and which
18 provides medical care (within the meaning of section
19 733(a)(2)), any law of any State which regulates in-
20 surance may apply.”.

21 (D) Section 514(e) of such Act (as redesign-
22 nated by subparagraph (B)(iii)) is amended—

23 (i) by striking “Nothing” and insert-
24 ing “(1) Except as provided in paragraph
25 (2), nothing”; and

1 (ii) by adding at the end the following
2 new paragraph:

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of part 8 shall be
5 construed to alter, amend, modify, invalidate, impair, or
6 supersede any provision of this title, except by specific
7 cross-reference to the affected section.”.

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

13 (4) DISCLOSURE OF SOLVENCY PROTECTIONS
14 RELATED TO SELF-INSURED AND FULLY INSURED
15 OPTIONS UNDER ASSOCIATION HEALTH PLANS.—
16 Section 102(b) of such Act (29 U.S.C. 102(b)) is
17 amended by adding at the end the following: “An as-
18 sociation health plan shall include in its summary
19 plan description, in connection with each benefit op-
20 tion, a description of the form of solvency or guar-
21 antee fund protection secured pursuant to this Act
22 or applicable State law, if any.”.

23 (5) SAVINGS CLAUSE.—Section 731(c) of such
24 Act is amended by inserting “or part 8” after “this
25 part”.

1 (6) REPORT TO THE CONGRESS REGARDING
2 CERTIFICATION OF SELF-INSURED ASSOCIATION
3 HEALTH PLANS.—Not later than January 1, 2012,
4 the Secretary of Labor shall report to the Committee
5 on Education and the Workforce of the House of
6 Representatives and the Committee on Health, Edu-
7 cation, Labor, and Pensions of the Senate the effect
8 association health plans have had, if any, on reduc-
9 ing the number of uninsured individuals.

10 (7) CLERICAL AMENDMENT.—The table of con-
11 tents in section 1 of the Employee Retirement In-
12 come Security Act of 1974 is amended by inserting
13 after the item relating to section 734 the following
14 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.”.

15 (b) CLARIFICATION OF TREATMENT OF SINGLE EM-
16 PLOYER ARRANGEMENTS.—Section 3(40)(B) of the Em-

1 ployee Retirement Income Security Act of 1974 (29
2 U.S.C. 1002(40)(B)) is amended—

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

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

16 “(iii)(I) in any case in which the benefit re-
17 ferred to in subparagraph (A) consists of medical
18 care (as defined in section 812(a)(2)), the deter-
19 mination of whether a trade or business is under
20 ‘common control’ with another trade or business
21 shall be determined under regulations of the Sec-
22 retary applying principles consistent and coextensive
23 with the principles applied in determining whether
24 employees of two or more trades or businesses are
25 treated as employed by a single employer under sec-

1 tion 4001(b), except that, for purposes of this para-
2 graph, an interest of greater than 25 percent may
3 not be required as the minimum interest necessary
4 for common control, or

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

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

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

10 “(iv) in any case in which the benefit referred
11 to in subparagraph (A) consists of medical care (as
12 defined in section 812(a)(2)), in determining, after
13 the application of clause (I), whether benefits are
14 provided to employees of two or more employers, the
15 arrangement shall be treated as having only one par-
16 ticipating employer if, after the application of clause
17 (I), the number of individuals who are employees
18 and former employees of any one participating em-
19 ployer and who are covered under the arrangement
20 is greater than 75 percent of the aggregate number
21 of all individuals who are employees or former em-
22 ployees of participating employers and who are cov-
23 ered under the arrangement,”.

24 (c) ENFORCEMENT PROVISIONS RELATING TO ASSO-
25 CIATION HEALTH PLANS.—

1 (1) CRIMINAL PENALTIES FOR CERTAIN WILL-
2 FUL MISREPRESENTATIONS.—Section 501 of the
3 Employee Retirement Income Security Act of 1974
4 (29 U.S.C. 1131) is amended—

5 (A) by inserting “(a)” after “Sec. 501.”;
6 and

7 (B) by adding at the end the following new
8 subsection:

9 “(b) Any person who willfully falsely represents, to
10 any employee, any employee’s beneficiary, any employer,
11 the Secretary, or any State, a plan or other arrangement
12 established or maintained for the purpose of offering or
13 providing any benefit described in section 3(1) to employ-
14 ees or their beneficiaries as—

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

17 “(2) having been established or maintained
18 under or pursuant to one or more collective bar-
19 gaining agreements which are reached pursuant to
20 collective bargaining described in section 8(d) of the
21 National Labor Relations Act (29 U.S.C. 158(d)) or
22 paragraph Fourth of section 2 of the Railway Labor
23 Act (45 U.S.C. 152, paragraph Fourth) or which are
24 reached pursuant to labor-management negotiations

1 under similar provisions of State public employee re-
2 lations laws; or

3 “(3) being a plan or arrangement described in
4 section 3(40)(A)(I),

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

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

11 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
12 SIST ORDERS.—

13 “(1) IN GENERAL.—Subject to paragraph (2),
14 upon application by the Secretary showing the oper-
15 ation, promotion, or marketing of an association
16 health plan (or similar arrangement providing bene-
17 fits consisting of medical care (as defined in section
18 733(a)(2))) that—

19 “(A) is not certified under part 8, is sub-
20 ject under section 514(b)(6) to the insurance
21 laws of any State in which the plan or arrange-
22 ment offers or provides benefits, and is not li-
23 censed, registered, or otherwise approved under
24 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 (3) RESPONSIBILITY FOR CLAIMS PROCE-
2 DURE.—Section 503 of such Act (29 U.S.C. 1133)
3 is amended by inserting “(a) IN GENERAL.—” be-
4 fore “In accordance”, and by adding at the end the
5 following new subsection:

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

12 (d) COOPERATION BETWEEN FEDERAL AND STATE
13 AUTHORITIES.—Section 506 of the Employee Retirement
14 Income Security Act of 1974 (29 U.S.C. 1136) is amended
15 by adding at the end the following new subsection:

16 “(d) CONSULTATION WITH STATES WITH RESPECT
17 TO ASSOCIATION HEALTH PLANS.—

18 “(1) AGREEMENTS WITH STATES.—The Sec-
19 retary shall consult with the State recognized under
20 paragraph (2) with respect to an association health
21 plan regarding the exercise of—

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

1 “(B) the Secretary’s authority to certify
2 association health plans under part 8 in accord-
3 ance with regulations of the Secretary applica-
4 ble to certification under part 8.

5 “(2) RECOGNITION OF PRIMARY DOMICILE
6 STATE.—In carrying out paragraph (1), the Sec-
7 retary shall ensure that only one State will be recog-
8 nized, with respect to any particular association
9 health plan, as the State with which consultation is
10 required. In carrying out this paragraph—

11 “(A) in the case of a plan which provides
12 health insurance coverage (as defined in section
13 812(a)(3)), such State shall be the State with
14 which filing and approval of a policy type of-
15 fered by the plan was initially obtained, and

16 “(B) in any other case, the Secretary shall
17 take into account the places of residence of the
18 participants and beneficiaries under the plan
19 and the State in which the trust is main-
20 tained.”.

21 (e) EFFECTIVE DATE AND TRANSITIONAL AND
22 OTHER RULES.—

23 (1) EFFECTIVE DATE.—The amendments made
24 by this section shall take effect 1 year after the date
25 of the enactment of this Act. The Secretary of Labor

1 shall first issue all regulations necessary to carry out
2 such amendments within 1 year after the date of the
3 enactment of this Act.

4 (2) TREATMENT OF CERTAIN EXISTING
5 HEALTH BENEFITS PROGRAMS.—

6 (A) IN GENERAL.—In any case in which,
7 as of the date of the enactment of this Act, an
8 arrangement is maintained in a State for the
9 purpose of providing benefits consisting of med-
10 ical care for the employees and beneficiaries of
11 its participating employers, at least 200 partici-
12 200 participating employers make contributions to such
13 arrangement, such arrangement has been in ex-
14 10 years, and such arrange-
15 ment is licensed under the laws of one or more
16 States to provide such benefits to its partici-
17 200 participating employers, upon the filing with the ap-
18 200 applicable authority (as defined in section
19 812(a)(5) of the Employee Retirement Income
20 Security Act of 1974 (as amended by this sub-
21 200 title)) by the arrangement of an application for
22 200 certification of the arrangement under part 8 of
23 200 subtitle B of title I of such Act—

1 (i) such arrangement shall be deemed
2 to be a group health plan for purposes of
3 title I of such Act;

4 (ii) the requirements of sections
5 801(a) and 803(a) of the Employee Retirement
6 Income Security Act of 1974 shall be
7 deemed met with respect to such arrange-
8 ment;

9 (iii) the requirements of section
10 803(b) of such Act shall be deemed met, if
11 the arrangement is operated by a board of
12 directors which—

13 (I) is elected by the participating
14 employers, with each employer having
15 one vote; and

16 (II) has complete fiscal control
17 over the arrangement and which is re-
18 sponsible for all operations of the ar-
19 rangement;

20 (iv) the requirements of section
21 804(a) of such Act shall be deemed met
22 with respect to such arrangement; and

23 (v) the arrangement may be certified
24 by any applicable authority with respect to
25 its operations in any State only if it oper-

1 ates in such State on the date of certifi-
2 cation.

3 The provisions of this subparagraph shall cease
4 to apply with respect to any such arrangement
5 at such time after the date of the enactment of
6 this Act as the applicable requirements of this
7 subparagraph are not met with respect to such
8 arrangement.

9 (B) DEFINITIONS.—For purposes of this
10 paragraph, the terms “group health plan”,
11 “medical care”, and “participating employer”
12 shall have the meanings provided in section 812
13 of the Employee Retirement Income Security
14 Act of 1974, except that the reference in para-
15 graph (7) of such section to an “association
16 health plan” shall be deemed a reference to an
17 arrangement referred to in this paragraph.

18 **Subtitle C—Health Care Services**
19 **Commission**

20 **PART 1—ESTABLISHMENT AND GENERAL DUTIES**

21 **SEC. 121. ESTABLISHMENT.**

22 (a) IN GENERAL.—There is hereby established a
23 Health Care Services Commission (in this subtitle referred
24 to as the “Commission”) to be composed of five commis-
25 sioners (in this subtitle referred to as the “Commis-

1 sioners'') to be appointed by the President by and with
2 the advice and consent of the Senate. Not more than three
3 of such commissioners shall be members of the same polit-
4 ical party, and in making appointments members of dif-
5 ferent political parties shall be appointed alternately as
6 nearly as may be practicable. No commissioner shall en-
7 gage in any other business, vocation, or employment than
8 that of serving as commissioner. Each commissioner shall
9 hold office for a term of five years and until his successor
10 is appointed and has qualified, except that he shall not
11 so continue to serve beyond the expiration of the next ses-
12 sion of Congress subsequent to the expiration of said fixed
13 term of office, and except (1) any commissioner appointed
14 to fill a vacancy occurring prior to the expiration of the
15 term for which his predecessor was appointed shall be ap-
16 pointed for the remainder of such term, and (2) the terms
17 of office of the commissioners first taking office after the
18 enactment of this subtitle shall expire as designated by
19 the President at the time of nomination, one at the end
20 of one year, one at the end of two years, one at the end
21 of three years, one at the end of four years, and one at
22 the end of five years, after the date of the enactment of
23 this Act.

24 (b) PURPOSE.—The purpose of the Commission is to
25 enhance the quality, appropriateness, and effectiveness of

1 health care services, and access to such services, through
2 the establishment of a broad base of scientific research
3 and through the promotion of improvements in clinical
4 practice and in the organization, financing, and delivery
5 of health care services.

6 (c) APPOINTMENT OF CHAIRMAN.—The President
7 shall, from among the Commissioners appointed under
8 subsection (a), designate an individual to serve as the
9 Chairman of the Commission.

10 **SEC. 122. GENERAL AUTHORITIES AND DUTIES.**

11 (a) IN GENERAL.—In carrying out section 121(b),
12 the Commissioners shall conduct and support research,
13 demonstration projects, evaluations, training, guideline de-
14 velopment, and the dissemination of information, on
15 health care services and on systems for the delivery of
16 such services, including activities with respect to—

17 (1) the effectiveness, efficiency, and quality of
18 health care services;

19 (2) subject to subsection (d), the outcomes of
20 health care services and procedures;

21 (3) clinical practice, including primary care and
22 practice-oriented research;

23 (4) health care technologies, facilities, and
24 equipment;

1 (5) health care costs, productivity, and market
2 forces;

3 (6) health promotion and disease prevention;

4 (7) health statistics and epidemiology; and

5 (8) medical liability.

6 (b) REQUIREMENTS WITH RESPECT TO RURAL
7 AREAS AND UNDERSERVED POPULATIONS.—In carrying
8 out subsection (a), the Commissioners shall undertake and
9 support research, demonstration projects, and evaluations
10 with respect to—

11 (1) the delivery of health care services in rural
12 areas (including frontier areas); and

13 (2) the health of low-income groups, minority
14 groups, and the elderly.

15 **SEC. 123. DISSEMINATION.**

16 (a) IN GENERAL.—The Commissioners shall—

17 (1) promptly publish, make available, and oth-
18 erwise disseminate, in a form understandable and on
19 as broad a basis as practicable so as to maximize its
20 use, the results of research, demonstration projects,
21 and evaluations conducted or supported under this
22 subtitle and the guidelines, standards, and review
23 criteria developed under this subtitle;

1 (2) promptly make available to the public data
2 developed in such research, demonstration projects,
3 and evaluations; and

4 (3) as appropriate, provide technical assistance
5 to State and local government and health agencies
6 and conduct liaison activities to such agencies to fos-
7 ter dissemination.

8 (b) PROHIBITION AGAINST RESTRICTIONS.—Except
9 as provided in subsection (c), the Commissioners may not
10 restrict the publication or dissemination of data from, or
11 the results of, projects conducted or supported under this
12 subtitle.

13 (c) LIMITATION ON USE OF CERTAIN INFORMA-
14 TION.—No information, if an establishment or person sup-
15 plying the information or described in it is identifiable,
16 obtained in the course of activities undertaken or sup-
17 ported under this subtitle may be used for any purpose
18 other than the purpose for which it was supplied unless
19 such establishment or person has consented (as deter-
20 mined under regulations of the Secretary) to its use for
21 such other purpose. Such information may not be pub-
22 lished or released in other form if the person who supplied
23 the information or who is described in it is identifiable
24 unless such person has consented (as determined under

1 regulations of the Secretary) to its publication or release
2 in other form.

3 (d) CERTAIN INTERAGENCY AGREEMENT.—The
4 Commissioners and the Director of the National Library
5 of Medicine shall enter into an agreement providing for
6 the implementation of subsection (a)(1).

7 **PART 2—FORUM FOR QUALITY AND**
8 **EFFECTIVENESS IN HEALTH CARE**

9 **SEC. 131. ESTABLISHMENT OF OFFICE.**

10 There is established within the Commission an office
11 to be known as the Office of the Forum for Quality and
12 Effectiveness in Health Care. The office shall be headed
13 by a director (referred to in this subtitle as the “Direc-
14 tor”), who shall be appointed by the Commissioners.

15 **SEC. 132. MEMBERSHIP.**

16 (a) IN GENERAL.—The Office of the Forum for Qual-
17 ity and Effectiveness in Health Care shall be composed
18 of 15 individuals nominated by private sector health care
19 organizations and appointed by the Commission and shall
20 include representation from at least the following:

- 21 (1) Health insurance industry.
22 (2) Health care provider groups.
23 (3) Non-profit organizations.
24 (4) Rural health organizations.

25 (b) TERMS.—

1 (1) IN GENERAL.—Except as provided in sub-
2 paragraph (B), members of the Office of the Forum
3 for Quality and Effectiveness in Health Care shall
4 serve for a term of 5 years.

5 (2) STAGGERED ROTATION.—Of the members
6 first appointed to the Office of the Forum for Qual-
7 ity and Effectiveness in Health Care, the Commis-
8 sion shall appoint 5 members to serve for a term of
9 2 years, 5 members to serve for a term of 3 years,
10 and 5 members to serve for a term of 4 years.

11 (c) TREATMENT OF OTHER EMPLOYMENT.—Each
12 member of the Office of the Forum for Quality and Effec-
13 tiveness in Health Care shall serve the Office independ-
14 ently from any other position of employment.

15 **SEC. 133. DUTIES.**

16 (a) ESTABLISHMENT OF FORUM PROGRAM.—The
17 Commissioners, acting through the Director, shall estab-
18 lish a program to be known as the Forum for Quality and
19 Effectiveness in Health Care. For the purpose of pro-
20 moting transparency in price, quality, appropriateness,
21 and effectiveness of health care, the Director, using the
22 process set forth in section 134, shall arrange for the de-
23 velopment and periodic review and updating of standards
24 of quality, performance measures, and medical review cri-
25 teria through which health care providers and other appro-

1 priate entities may assess or review the provision of health
2 care and assure the quality of such care.

3 (b) CERTAIN REQUIREMENTS.—Guidelines, stand-
4 ards, performance measures, and review criteria under
5 subsection (a) shall—

6 (1) be based on the best available research and
7 professional judgment regarding the effectiveness
8 and appropriateness of health care services and pro-
9 cedures; and

10 (2) be presented in formats appropriate for use
11 by physicians, health care practitioners, providers,
12 medical educators, and medical review organizations
13 and in formats appropriate for use by consumers of
14 health care.

15 (c) AUTHORITY FOR CONTRACTS.—In carrying out
16 this part, the Director may enter into contracts with pub-
17 lic or nonprofit private entities.

18 (d) PUBLIC DISCLOSURE OF RECOMMENDATIONS.—
19 For each fiscal year beginning with 2010, the Director
20 shall make publicly available the following:

21 (1) quarterly reports for public comment that
22 include proposed recommendations for guidelines,
23 standards, performance measures, and review cri-
24 teria under subsection (a) and any updates to such

1 guidelines, standards, performance measures, and
2 review criteria; and

3 (2) after consideration of such comments, a
4 final report that contains final recommendations for
5 such guidelines, standards, performance measures,
6 review criteria, and updates.

7 (e) DATE CERTAIN FOR INITIAL GUIDELINES AND
8 STANDARDS.—The Commissioners, by not later than Jan-
9 uary 1, 2012, shall assure the development of an initial
10 set of guidelines, standards, performance measures, and
11 review criteria under subsection (a).

12 **SEC. 134. ADOPTION AND ENFORCEMENT OF GUIDELINES**
13 **AND STANDARDS.**

14 (a) ADOPTION OF RECOMMENDATIONS OF FORUM
15 FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—
16 For each fiscal year, the Commissioners shall adopt the
17 recommendations made for such year in the final report
18 under subsection (d)(2) of section 133 for guidelines,
19 standards, performance measures, and review criteria de-
20 scribed in subsection (a) of such section.

21 (b) ENFORCEMENT AUTHORITY.—The Commis-
22 sioners , in consultation with the Secretary of Health and
23 Human Services, have the authority to make recommenda-
24 tions to the Secretary to enforce compliance of health care
25 providers with the guidelines, standards, performance

1 measures, and review criteria adopted under subsection
2 (a). Such recommendations may include the following,
3 with respect to a health care provider who is not in compli-
4 ance with such guidelines, standards, measures, and cri-
5 teria:

6 (1) Exclusion from participation in Federal
7 health care programs (as defined in section
8 1128B(f) of the Social Security Act).

9 (2) Imposition of a civil money penalty on such
10 provider.

11 **SEC. 135. ADDITIONAL REQUIREMENTS.**

12 (a) PROGRAM AGENDA.—The Commissioners shall
13 provide for an agenda for the development of the guide-
14 lines, standards, performance measures, and review cri-
15 teria described in section 133(a), including with respect
16 to the standards, performance measures, and review cri-
17 teria, identifying specific aspects of health care for which
18 the standards, performance measures, and review criteria
19 are to be developed and those that are to be given priority
20 in the development of the standards, performance meas-
21 ures, and review criteria.

22 **PART 3—GENERAL PROVISIONS**

23 **SEC. 141. CERTAIN ADMINISTRATIVE AUTHORITIES.**

24 The Commissioners, in carrying out this subtitle, may
25 accept voluntary and uncompensated services.

1 **SEC. 142. FUNDING.**

2 For the purpose of carrying out this subtitle, there
3 are authorized to be appropriated such sums as may be
4 necessary for fiscal years 2010 through 2014.

5 **SEC. 143. DEFINITIONS.**

6 For purposes of this subtitle:

7 (1) The term “Commissioners” means the Com-
8 missioners of the Health Care Services Commission.

9 (2) The term “Commission” means the Health
10 Care Services Commission.

11 (3) The term “Director” means the Director of
12 the Office of the Forum for Quality and Effective-
13 ness in Health Care.

14 (4) The term “Secretary” means the Secretary
15 of Health and Human Services.

16 **PART 4—TERMINATIONS AND TRANSITION**

17 **SEC. 151. TERMINATION OF AGENCY FOR HEALTHCARE RE-**
18 **SEARCH AND QUALITY.**

19 As of the date of the enactment of this Act, the Agen-
20 cy for Healthcare Research and Quality is terminated, and
21 title IX of the Public Health Service Act is repealed.

22 **SEC. 152. TRANSITION.**

23 All orders, grants, contracts, privileges, and other de-
24 terminations or actions of the Agency for Healthcare Re-
25 search and Quality that are effective as of the date before
26 the date of the enactment of this Act, shall be transferred

1 to the Secretary and shall continue in effect according to
2 their terms unless changed pursuant to law.

3 **PART 5—INDEPENDENT HEALTH RECORD TRUST**

4 **SEC. 161. SHORT TITLE OF PART.**

5 This part may be cited as the “Independent Health
6 Record Trust Act of 2008”.

7 **SEC. 162. PURPOSE.**

8 It is the purpose of this part et to provide for the
9 establishment of a nationwide health information tech-
10 nology network that—

11 (1) improves health care quality, reduces med-
12 ical errors, increases the efficiency of care, and ad-
13 vances the delivery of appropriate, evidence-based
14 health care services;

15 (2) promotes wellness, disease prevention, and
16 the management of chronic illnesses by increasing
17 the availability and transparency of information re-
18 lated to the health care needs of an individual;

19 (3) ensures that appropriate information nec-
20 essary to make medical decisions is available in a us-
21 able form at the time and in the location that the
22 medical service involved is provided;

23 (4) produces greater value for health care ex-
24 penditures by reducing health care costs that result

1 from inefficiency, medical errors, inappropriate care,
2 and incomplete information;

3 (5) promotes a more effective marketplace,
4 greater competition, greater systems analysis, in-
5 creased choice, enhanced quality, and improved out-
6 comes in health care services;

7 (6) improves the coordination of information
8 and the provision of such services through an effec-
9 tive infrastructure for the secure and authorized ex-
10 change and use of health information; and

11 (7) ensures that the health information privacy,
12 security, and confidentiality of individually identifi-
13 able health information is protected.

14 **SEC. 163. DEFINITIONS.**

15 In this part:

16 (1) **ACCESS.**—The term “access” means, with
17 respect to an electronic health record, entering infor-
18 mation into such account as well as retrieving infor-
19 mation from such account.

20 (2) **ACCOUNT.**—The term “account” means an
21 electronic health record of an individual contained in
22 an independent health record trust.

23 (3) **AFFIRMATIVE CONSENT.**—The term “af-
24 firmative consent” means, with respect to an elec-
25 tronic health record of an individual contained in an

1 IHRT, express consent given by the individual for
2 the use of such record in response to a clear and
3 conspicuous request for such consent or at the indi-
4 vidual's own initiative.

5 (4) AUTHORIZED EHR DATA USER.—The term
6 “authorized EHR data user” means, with respect to
7 an electronic health record of an IHRT participant
8 contained as part of an IHRT, any entity (other
9 than the participant) authorized (in the form of af-
10 firmative consent) by the participant to access the
11 electronic health record.

12 (5) CONFIDENTIALITY.—The term “confiden-
13 tiality” means, with respect to individually identifi-
14 able health information of an individual, the obliga-
15 tion of those who receive such information to respect
16 the health information privacy of the individual.

17 (6) ELECTRONIC HEALTH RECORD.—The term
18 “electronic health record” means a longitudinal col-
19 lection of information concerning a single individual,
20 including medical records and personal health infor-
21 mation, that is stored electronically.

22 (7) HEALTH INFORMATION PRIVACY.—The
23 term “health information privacy” means, with re-
24 spect to individually identifiable health information
25 of an individual, the right of such individual to con-

1 trol the acquisition, uses, or disclosures of such in-
2 formation.

3 (8) HEALTH PLAN.—The term “health plan”
4 means a group health plan (as defined in section
5 2208(1) of the Public Health Service Act (42 U.S.C.
6 300bb–8(1))) as well as a plan that offers health in-
7 surance coverage in the individual market.

8 (9) HIPAA PRIVACY REGULATIONS.—The term
9 “HIPAA privacy regulations” means the regulations
10 promulgated under section 264(c) of the Health In-
11 surance Portability and Accountability Act of 1996
12 (42 U.S.C. 1320d–2 note).

13 (10) INDEPENDENT HEALTH RECORD TRUST;
14 IHRT.—The terms “independent health record trust”
15 and “IHRT” mean a legal arrangement under the
16 administration of an IHRT operator that meets the
17 requirements of this part with respect to electronic
18 health records of individuals participating in the
19 trust or IHRT.

20 (11) IHRT OPERATOR.—The term “IHRT op-
21 erator” means, with respect to an IHRT, the organi-
22 zation that is responsible for the administration and
23 operation of the IHRT in accordance with this part.

24 (12) IHRT PARTICIPANT.—The term “IHRT
25 participant” means, with respect to an IHRT, an in-

1 individual who has a participation agreement in effect
2 with respect to the maintenance of the individual's
3 electronic health record by the IHRT.

4 (13) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
5 FORMATION.—The term “individually identifiable
6 health information” has the meaning given such
7 term in section 1171(6) of the Social Security Act
8 (42 U.S.C. 1320d(6)).

9 (14) SECURITY.—The term “security” means,
10 with respect to individually identifiable health infor-
11 mation of an individual, the physical, technological,
12 or administrative safeguards or tools used to protect
13 such information from unwarranted access or disclo-
14 sure.

15 **SEC. 164. ESTABLISHMENT, CERTIFICATION, AND MEMBER-**
16 **SHIP OF INDEPENDENT HEALTH RECORD**
17 **TRUSTS.**

18 (a) ESTABLISHMENT.—Not later than one year after
19 the date of the enactment of this Act, the Federal Trade
20 Commission, in consultation with the National Committee
21 on Vital and Health Statistics, shall prescribe standards
22 for the establishment, certification, operation, and inter-
23 operability of IHRTs to carry out the purposes described
24 in section 162 in accordance with the provisions of this
25 part.

1 (b) CERTIFICATION.—

2 (1) CERTIFICATION BY FTC.—The Federal
3 Trade Commission shall provide for the certification
4 of IHRTs. No IHRT may be certified unless the
5 IHRT is determined to meet the standards for cer-
6 tification established under subsection (a).

7 (2) DECERTIFICATION.—The Federal Trade
8 Commission shall establish a process for the revoca-
9 tion of certification of an IHRT under this section
10 in the case that the IHRT violates the standards es-
11 tablished under subsection (a).

12 (c) MEMBERSHIP.—

13 (1) IN GENERAL.—To be eligible to be a partic-
14 ipant in an IHRT, an individual shall—

15 (A) submit to the IHRT information as re-
16 quired by the IHRT to establish an electronic
17 health record with the IHRT; and

18 (B) enter into a privacy protection agree-
19 ment described in section 166(b)(1) with the
20 IHRT.

21 The process to determine eligibility of an individual
22 under this subsection shall allow for the establish-
23 ment by such individual of an electronic health
24 record as expeditiously as possible if such individual
25 is determined so eligible.

1 (2) NO LIMITATION ON MEMBERSHIP.—Nothing
2 in this subsection shall be construed to permit an
3 IHRT to restrict membership, including on the basis
4 of health condition.

5 **SEC. 165. DUTIES OF IHRT TO IHRT PARTICIPANTS.**

6 (a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR
7 VIOLATIONS OF FIDUCIARY DUTY.—

8 (1) FIDUCIARY DUTY.—With respect to the
9 electronic health record of an IHRT participant
10 maintained by an IHRT, the IHRT shall have a fi-
11 duciary duty to act for the benefit and in the inter-
12 ests of such participant and of the IHRT as a whole.
13 Such duty shall include obtaining the affirmative
14 consent of such participant prior to the release of in-
15 formation in such participant's electronic health
16 record in accordance with the requirements of this
17 part.

18 (2) PENALTIES.—If the IHRT knowingly or
19 recklessly breaches the fiduciary duty described in
20 paragraph (1), the IHRT shall be subject to the fol-
21 lowing penalties:

22 (A) Loss of certification of the IHRT.

23 (B) A fine that is not in excess of \$50,000.

24 (C) A term of imprisonment for the indi-
25 viduals involved of not more than 5 years.

1 (b) ELECTRONIC HEALTH RECORD DEEMED TO BE
2 HELD IN TRUST BY IHRT.—With respect to an indi-
3 vidual, an electronic health record maintained by an IHRT
4 shall be deemed to be held in trust by the IHRT for the
5 benefit of the individual and the IHRT shall have no legal
6 or equitable interest in such electronic health record.

7 **SEC. 166. AVAILABILITY AND USE OF INFORMATION FROM**
8 **RECORDS IN IHRT CONSISTENT WITH PRI-**
9 **VACY PROTECTIONS AND AGREEMENTS.**

10 (a) PROTECTED ELECTRONIC HEALTH RECORDS
11 USE AND ACCESS.—

12 (1) GENERAL RIGHTS REGARDING USES OF IN-
13 FORMATION.—

14 (A) IN GENERAL.—With respect to the
15 electronic health record of an IHRT participant
16 maintained by an IHRT, subject to paragraph
17 (2)(C), primary uses and secondary uses (de-
18 scribed in subparagraphs (B) and (C), respec-
19 tively) of information within such record (other
20 than by such participant) shall be permitted
21 only upon the authorization of such use, prior
22 to such use, by such participant.

23 (B) PRIMARY USES.—For purposes of sub-
24 paragraph (A) and with respect to an electronic
25 health record of an individual, a primary use is

1 a use for purposes of the individual's self-care
2 or care by health care professionals.

3 (C) SECONDARY USES.—For purposes of
4 subparagraph (B) and with respect to an elec-
5 tronic health record of an individual, a sec-
6 ondary use is any use not described in subpara-
7 graph (B) and includes a use for purposes of
8 public health research or other related activi-
9 ties. Additional authorization is required for a
10 secondary use extending beyond the original
11 purpose of the secondary use authorized by the
12 IHRT participant involved. Nothing in this
13 paragraph shall be construed as requiring au-
14 thorization for every secondary use that is with-
15 in the authorized original purpose.

16 (2) RULES FOR PRIMARY USE OF RECORDS FOR
17 HEALTH CARE PURPOSES.—With respect to the elec-
18 tronic health record of an IHRT participant (or
19 specified parts of such electronic health record)
20 maintained by an IHRT standards for access to
21 such record shall provide for the following:

22 (A) ACCESS BY IHRT PARTICIPANTS TO
23 THEIR ELECTRONIC HEALTH RECORDS.—

24 (i) OWNERSHIP.—The participant
25 maintains ownership over the entire elec-

1 tronic health record (and all portions of
2 such record) and shall have the right to
3 electronically access and review the con-
4 tents of the entire record (and any portion
5 of such record) at any time, in accordance
6 with this subparagraph.

7 (ii) ADDITION OF PERSONAL INFOR-
8 MATION.—The participant may add per-
9 sonal health information to the health
10 record of that participant, except that such
11 participant shall not alter information that
12 is entered into the electronic health record
13 by any authorized EHR data user. Such
14 participant shall have the right to propose
15 an amendment to information that is en-
16 tered by an authorized EHR data user
17 pursuant to standards prescribed by the
18 Federal Trade Commission for purposes of
19 amending such information.

20 (iii) IDENTIFICATION OF INFORMA-
21 TION ENTERED BY PARTICIPANT.—Any ad-
22 ditions or amendments made by the partic-
23 ipant to the health record shall be identi-
24 fied and disclosed within such record as
25 being made by such participant.

1 (B) ACCESS BY ENTITIES OTHER THAN
2 IHRT PARTICIPANT.—

3 (i) AUTHORIZED ACCESS ONLY.—Ex-
4 cept as provided under subparagraph (C)
5 and paragraph (4), access to the electronic
6 health record (or any portion of the
7 record)—

8 (I) may be made only by author-
9 ized EHR data users and only to such
10 portions of the record as specified by
11 the participant; and

12 (II) may be limited by the partic-
13 ipant for purposes of entering infor-
14 mation into such record, retrieving in-
15 formation from such record, or both.

16 (ii) IDENTIFICATION OF ENTITY THAT
17 ENTERS INFORMATION.—Any information
18 that is added by an authorized EHR data
19 user to the health record shall be identified
20 and disclosed within such record as being
21 made by such user.

22 (iii) SATISFACTION OF HIPAA PRIVACY
23 REGULATIONS.—In the case of a record of
24 a covered entity (as defined for purposes of
25 HIPAA privacy regulations), with respect

1 to an individual, if such individual is an
2 IHRT participant with an independent
3 health record trust and such covered entity
4 is an authorized EHR data user, the re-
5 quirement under the HIPAA privacy regu-
6 lations for such entity to provide the
7 record to the participant shall be deemed
8 met if such entity, without charge to the
9 IHRT or the participant—

10 (I) forwards to the trust an ap-
11 propriately formatted electronic copy
12 of the record (and updates to such
13 records) for inclusion in the electronic
14 health record of the participant main-
15 tained by the trust;

16 (II) enters such record into the
17 electronic health record of the partici-
18 pant so maintained; or

19 (III) otherwise makes such
20 record available for electronic access
21 by the IHRT or the individual in a
22 manner that permits such record to
23 be included in the account of the indi-
24 vidual contained in the IHRT.

1 (iv) NOTIFICATION OF SENSITIVE IN-
2 FORMATION.—Any information, with re-
3 spect to the participant, that is sensitive
4 information, as specified by the Federal
5 Trade Commission, shall not be forwarded
6 or entered by an authorized EHR data
7 user into the electronic health record of the
8 participant maintained by the trust unless
9 the user certifies that the participant has
10 been notified of such information.

11 (C) DEEMED AUTHORIZATION FOR ACCESS
12 FOR EMERGENCY HEALTH CARE.—

13 (i) FINDINGS.—Congress finds that—

14 (I) given the size and nature of
15 visits to emergency departments in
16 the United States, readily available
17 health information could make the dif-
18 ference between life and death; and

19 (II) because of the case mix and
20 volume of patients treated, emergency
21 departments are well positioned to
22 provide information for public health
23 surveillance, community risk assess-
24 ment, research, education, training,
25 quality improvement, and other uses.

1 (ii) USE OF INFORMATION.—With re-
2 spect to the electronic health record of an
3 IHRT participant (or specified parts of
4 such electronic health record) maintained
5 by an IHRT, the participant shall be
6 deemed as providing authorization (in the
7 form of affirmative consent) for health
8 care providers to access, in connection with
9 providing emergency care services to the
10 participant, a limited, authenticated infor-
11 mation set concerning the participant for
12 emergency response purposes, unless the
13 participant specifies that such information
14 set (or any portion of such information
15 set) may not be so accessed. Such limited
16 information set may include information—
17 (I) patient identification data, as
18 determined appropriate by the partici-
19 pant;
20 (II) provider identification that
21 includes the use of unique provider
22 identifiers;
23 (III) payment information;

1 (IV) information related to the
2 individual's vitals, allergies, and medi-
3 cation history;

4 (V) information related to exist-
5 ing chronic problems and active clin-
6 ical conditions of the participant; and

7 (VI) information concerning
8 physical examinations, procedures, re-
9 sults, and diagnosis data.

10 (3) RULES FOR SECONDARY USES OF RECORDS
11 FOR RESEARCH AND OTHER PURPOSES.—

12 (A) IN GENERAL.—With respect to the
13 electronic health record of an IHRT participant
14 (or specified parts of such electronic health
15 record) maintained by an IHRT, the IHRT
16 may sell such record (or specified parts of such
17 record) only if—

18 (i) the transfer is authorized by the
19 participant pursuant to an agreement be-
20 tween the participant and the IHRT and is
21 in accordance with the privacy protection
22 agreement described in subsection (b)(1)
23 entered into between such participant and
24 such IHRT;

1 (ii) such agreement includes param-
2 eters with respect to the disclosure of in-
3 formation involved and a process for the
4 authorization of the further disclosure of
5 information in such record;

6 (iii) the information involved is to be
7 used for research or other activities only as
8 provided for in the agreement;

9 (iv) the recipient of the information
10 provides assurances that the information
11 will not be further transferred or reused in
12 violation of such agreement; and

13 (v) the transfer otherwise meets the
14 requirements and standards prescribed by
15 the Federal Trade Commission.

16 (B) TREATMENT OF PUBLIC HEALTH RE-
17 PORTING.—Nothing in this paragraph shall be
18 construed as prohibiting or limiting the use of
19 health care information of an individual, includ-
20 ing an individual who is an IHRT participant,
21 for public health reporting (or other research)
22 purposes prior to the inclusion of such informa-
23 tion in an electronic health record maintained
24 by an IHRT.

1 (4) LAW ENFORCEMENT CLARIFICATION.—
2 Nothing in this part shall prevent an IHRT from
3 disclosing information contained in an electronic
4 health record maintained by the IHRT when re-
5 quired for purposes of a lawful investigation or offi-
6 cial proceeding inquiring into a violation of, or fail-
7 ure to comply with, any criminal or civil statute or
8 any regulation, rule, or order issued pursuant to
9 such a statute.

10 (5) RULE OF CONSTRUCTION.—Nothing in this
11 section shall be construed to require a health care
12 provider that does not utilize electronic methods or
13 appropriate levels of health information technology
14 on the date of the enactment of this Act to adopt
15 such electronic methods or technology as a require-
16 ment for participation or compliance under this part.

17 (b) PRIVACY PROTECTION AGREEMENT; TREATMENT
18 OF STATE PRIVACY AND SECURITY LAWS.—

19 (1) PRIVACY PROTECTION AGREEMENT.—A pri-
20 vacy protection agreement described in this sub-
21 section is an agreement, with respect to an electronic
22 health record of an IHRT participant to be main-
23 tained by an independent health record trust, be-
24 tween the participant and the trust—

1 (A) that is consistent with the standards
2 described in subsection (a)(2);

3 (B) under which the participant specifies
4 the portions of the record that may be accessed,
5 under what circumstances such portions may be
6 accessed, any authorizations for indicated au-
7 thorized EHR data users to access information
8 contained in the record, and the purposes for
9 which the information (or portions of the infor-
10 mation) in the record may be used;

11 (C) which provides a process for the au-
12 thorization of the transfer of information con-
13 tained in the record to a third party, including
14 for the sale of such information for purposes of
15 research, by an authorized EHR data user and
16 reuse of such information by such third party,
17 including a provision requiring that such trans-
18 fer and reuse is not in violation of any privacy
19 or transfer restrictions placed by the partici-
20 pant on the independent health record of such
21 participant; and

22 (D) under which the trust provides assur-
23 ances that the trust will not transfer, disclose,
24 or provide access to the record (or any portion
25 of the record) in violation of the parameters es-

1 tablished in the agreement or to any person or
2 entity who has not agreed to use and transfer
3 such record (or portion of such record) in ac-
4 cordance with such agreement.

5 (2) TREATMENT OF STATE LAWS.—

6 (A) IN GENERAL.—Except as provided
7 under subparagraph (B), the provisions of a
8 privacy protection agreement entered into be-
9 tween an IHRT and an IHRT participant shall
10 preempt any provision of State law (or any
11 State regulation) relating to the privacy and
12 confidentiality of individually identifiable health
13 information or to the security of such health in-
14 formation.

15 (B) EXCEPTION FOR PRIVILEGED INFOR-
16 MATION.—The provisions of a privacy protec-
17 tion agreement shall not preempt any provision
18 of State law (or any State regulation) that rec-
19 ognizes privileged communications between phy-
20 sicians, health care practitioners, and patients
21 of such physicians or health care practitioners,
22 respectively.

23 (C) STATE DEFINED.—For purposes of
24 this section, the term “State” has the meaning
25 given such term when used in title XI of the

1 Social Security Act, as provided under section
2 1101(a) of such Act (42 U.S.C. 1301(a)).

3 **SEC. 167. VOLUNTARY NATURE OF TRUST PARTICIPATION**
4 **AND INFORMATION SHARING.**

5 (a) IN GENERAL.—Participation in an independent
6 health record trust, or authorizing access to information
7 from such a trust, is voluntary. No employer, health insur-
8 ance issuer, group health plan, health care provider, or
9 other person may require, as a condition of employment,
10 issuance of a health insurance policy, coverage under a
11 group health plan, the provision of health care services,
12 payment for such services, or otherwise, that an individual
13 participate in, or authorize access to information from, an
14 independent health record trust.

15 (b) ENFORCEMENT.—The penalties provided for in
16 subsection (a) of section 1177 of the Social Security Act
17 (42 U.S.C. 1320d–6) shall apply to a violation of sub-
18 section (a) in the same manner as such penalties apply
19 to a person in violation of subsection (a) of such section.

20 **SEC. 168. FINANCING OF ACTIVITIES.**

21 (a) IN GENERAL.—Except as provided in subsection
22 (b), an IHRT may generate revenue to pay for the oper-
23 ations of the IHRT through—

24 (1) charging IHRT participants account fees
25 for use of the trust;

1 (2) charging authorized EHR data users for ac-
2 cessing electronic health records maintained in the
3 trust;

4 (3) the sale of information contained in the
5 trust (as provided for in section 166(a)(3)(A)); and

6 (4) any other activity determined appropriate
7 by the Federal Trade Commission.

8 (b) PROHIBITION AGAINST ACCESS FEES FOR
9 HEALTH CARE PROVIDERS.—For purposes of providing
10 incentives to health care providers to access information
11 maintained in an IHRT, as authorized by the IHRT par-
12 ticipants involved, the IHRT may not charge a fee for
13 services specified by the IHRT. Such services shall include
14 the transmittal of information from a health care provider
15 to be included in an independent electronic health record
16 maintained by the IHRT (or permitting such provider to
17 input such information into the record), including the
18 transmission of or access to information described in sec-
19 tion 166(a)(2)(C)(ii) by appropriate emergency respond-
20 ers.

21 (c) REQUIRED DISCLOSURES.—The sources and
22 amounts of revenue derived under subsection (a) for the
23 operations of an IHRT shall be fully disclosed to each
24 IHRT participant of such IHRT and to the public.

1 (d) TREATMENT OF INCOME.—For purposes of the
2 Internal Revenue Code of 1986, any revenue described in
3 subsection (a) shall not be included in gross income of any
4 IHRT, IHRT participant, or authorized EHR data user.

5 **SEC. 169. REGULATORY OVERSIGHT.**

6 (a) IN GENERAL.—In carrying out this part, the Fed-
7 eral Trade Commission shall promulgate regulations for
8 independent health record trusts.

9 (b) ESTABLISHMENT OF INTERAGENCY STEERING
10 COMMITTEE.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services shall establish an Interagency
13 Steering Committee in accordance with this sub-
14 section.

15 (2) CHAIRPERSON.—The Secretary of Health
16 and Human Services shall serve as the chairperson
17 of the Interagency Steering Committee.

18 (3) MEMBERSHIP.—The members of the Inter-
19 agency Steering Committee shall consist of the At-
20 torney General, the Chairperson of the Federal
21 Trade Commission, the Chairperson for the National
22 Committee for Vital and Health Statistics, a rep-
23 resentative of the Federal Reserve, and other Fed-
24 eral officials determined appropriate by the Sec-
25 retary of Health and Human Services.

1 (4) DUTIES.—The Interagency Steering Com-
2 mittee shall coordinate the implementation of this
3 part, including the implementation of policies de-
4 scribed in subsection (d) based upon the rec-
5 ommendations provided under such subsection, and
6 regulations promulgated under this part.

7 (c) FEDERAL ADVISORY COMMITTEE.—

8 (1) IN GENERAL.—The National Committee for
9 Vital and Health Statistics shall serve as an advisory
10 committee for the IHRTs. The membership of such
11 advisory committee shall include a representative
12 from the Federal Trade Commission and the chair-
13 person of the Interagency Steering Committee. Not
14 less than 60 percent of such membership shall con-
15 sist of representatives of nongovernment entities, at
16 least one of whom shall be a representative from an
17 organization representing health care consumers.

18 (2) DUTIES.—The National Committee for
19 Vital and Health Statistics shall issue periodic re-
20 ports and review policies concerning IHRTs based
21 on each of the following factors:

22 (A) Privacy and security policies.

23 (B) Economic progress.

24 (C) Interoperability standards.

1 (d) POLICIES RECOMMENDED BY FEDERAL TRADE
2 COMMISSION.—The Federal Trade Commission, in con-
3 sultation with the National Committee for Vital and
4 Health Statistics, shall recommend policies to—

5 (1) provide assistance to encourage the growth
6 of independent health record trusts;

7 (2) track economic progress as it pertains to
8 operators of independent health records trusts and
9 individuals receiving nontaxable income with respect
10 to accounts;

11 (3) conduct public education activities regarding
12 the creation and usage of the independent health
13 records trusts;

14 (4) establish standards for the interoperability
15 of health information technology to ensure that in-
16 formation contained in such record may be shared
17 between the trust involved, the participant, and au-
18 thorized EHR data users, including for the stand-
19 ardized collection and transmission of individual
20 health records (or portions of such records) to au-
21 thorized EHR data users through a common inter-
22 face and for the portability of such records among
23 independent health record trusts; and

24 (5) carry out any other activities determined
25 appropriate by the Federal Trade Commission.

1 (e) REGULATIONS PROMULGATED BY FEDERAL
2 TRADE COMMISSION.—The Federal Trade Commission
3 shall promulgate regulations based on, at a minimum, the
4 following factors:

5 (1) Requiring that an IHRT participant, who
6 has an electronic health record that is maintained by
7 an IHRT, be notified of a security breach with re-
8 spect to such record, and any corrective action taken
9 on behalf of the participant.

10 (2) Requiring that information sent to, or re-
11 ceived from, an IHRT that has been designated as
12 high-risk should be authenticated through the use of
13 methods such as the periodic changing of passwords,
14 the use of biometrics, the use of tokens or other
15 technology as determined appropriate by the council.

16 (3) Requiring a delay in releasing sensitive
17 health care test results and other similar informa-
18 tion to patients directly in order to give physicians
19 time to contact the patient.

20 (4) Recommendations for entities operating
21 IHRTs, including requiring analysis of the potential
22 risk of health transaction security breaches based on
23 set criteria.

1 (5) The conduct of audits of IHRTs to ensure
2 that they are in compliance with the requirements
3 and standards established under this part.

4 (6) Disclosure to IHRT participants of the
5 means by which such trusts are financed, including
6 revenue from the sale of patient data.

7 (7) Prevention of certification of an entity seek-
8 ing independent health record trust certification
9 based on—

10 (A) the potential for conflicts between the
11 interests of such entity and the security of the
12 health information involved; and

13 (B) the involvement of the entity in any
14 activity that is contrary to the best interests of
15 a patient.

16 (8) Prevention of the use of revenue sources
17 that are contrary to a patient's interests.

18 (9) Public disclosure of audits in a manner
19 similar to financial audits required for publicly trad-
20 ed stock companies.

21 (10) Requiring notification to a participating
22 entity that the information contained in such record
23 may not be representative of the complete or accu-
24 rate electronic health record of such account holder.

1 (f) COMPLIANCE REPORT.—Not later than 1 year
2 after the date of the enactment of this Act, and annually
3 thereafter, the Commission shall submit to the Committee
4 on Health, Education, Labor, and Pensions and the Com-
5 mittee on Finance of the Senate and the Committee on
6 Energy and Commerce and the Committee on Ways and
7 Means of the House of Representatives, a report on com-
8 pliance by and progress of independent health record
9 trusts with this part. Such report shall describe the fol-
10 lowing:

11 (1) The number of complaints submitted about
12 independent health record trusts, which shall be di-
13 vided by complaints related to security breaches, and
14 complaints not related to security breaches, and may
15 include other categories as the Interagency Steering
16 Committee established under subsection (b) deter-
17 mines appropriate.

18 (2) The number of enforcement actions under-
19 taken by the Commission against independent health
20 record trusts in response to complaints under para-
21 graph (1), which shall be divided by enforcement ac-
22 tions related to security breaches and enforcement
23 actions not related to security breaches and may in-
24 clude other categories as the Interagency Steering

1 Committee established under subsection (b) deter-
2 mines appropriate.

3 (3) The economic progress of the individual
4 owner or institution operator as achieved through
5 independent health record trust usage and existing
6 barriers to such usage.

7 (4) The progress in security auditing as pro-
8 vided for by the Interagency Steering Committee
9 council under subsection (b).

10 (5) The other core responsibilities of the Com-
11 mission as described in subsection (a).

12 (g) INTERAGENCY MEMORANDUM OF UNDER-
13 STANDING.—The Interagency Steering Committee shall
14 ensure, through the execution of an interagency memo-
15 randum of understanding, that—

16 (1) regulations, rulings, and interpretations
17 issued by Federal officials relating to the same mat-
18 ter over which 2 or more such officials have respon-
19 sibility under this part are administered so as to
20 have the same effect at all times; and

21 (2) the memorandum provides for the coordina-
22 tion of policies related to enforcing the same require-
23 ments through such officials in order to have coordi-
24 nated enforcement strategy that avoids duplication

1 of enforcement efforts and assigns priorities in en-
2 forcement.

3 **TITLE II—MEDICAID AND SCHIP**
4 **REFORM**

5 **SEC. 201. MEDICAID REFORM.**

6 (a) IN GENERAL.—Title XIX of the Social Security
7 Act is amended—

8 (1) by redesignating section 1939 as section
9 1940; and

10 (2) by inserting after section 1938 the following
11 new section:

12 “REVISION OF MEDICAID PROGRAM

13 “SEC. 1939. (a) ELECTION OF BLOCK GRANT OR IM-
14 PLEMENTATION OF REFUNDABLE TAX CREDIT FOR MED-
15 ICAID POPULATION FOR ACUTE CARE SERVICES AND
16 MAINTENANCE OF EFFORT SPENDING.—

17 “(1) IN GENERAL.—Each State shall elect—

18 “(A) to receive block grant funding under
19 subsection (b); or

20 “(B) to have Medicaid-eligible individuals
21 eligible to receive refundable tax credits under
22 section 36 of the Internal Revenue Code of
23 1986 and to provide for maintenance of effort
24 described in subsection (c).