

107TH CONGRESS  
1ST SESSION

# S. 683

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to establish State health insurance safety-net programs.

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## IN THE SENATE OF THE UNITED STATES

APRIL 3, 2001

Mr. SANTORUM (for himself, Mr. TORRICELLI, and Mr. SMITH of New Hampshire) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to establish State health insurance safety-net programs.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Fair Care for the Un-  
5 insured Act of 2001”.

1 **TITLE I—REFUNDABLE CREDIT**  
2 **FOR HEALTH INSURANCE**  
3 **COVERAGE**

4 **SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE**  
5 **COVERAGE.**

6 (a) IN GENERAL.—Subpart C of part IV of sub-  
7 chapter A of chapter 1 of the Internal Revenue Code of  
8 1986 (relating to refundable credits) is amended by redес-  
9 ignating section 35 as section 36 and by inserting after  
10 section 34 the following new section:

11 **“SEC. 35. HEALTH INSURANCE COSTS.**

12 “(a) IN GENERAL.—In the case of an individual,  
13 there shall be allowed as a credit against the tax imposed  
14 by this subtitle an amount equal to the amount paid dur-  
15 ing the taxable year for qualified health insurance for the  
16 taxpayer, his spouse, and dependents.

17 “(b) LIMITATIONS.—

18 “(1) IN GENERAL.—The amount allowed as a  
19 credit under subsection (a) to the taxpayer for the  
20 taxable year shall not exceed the sum of the monthly  
21 limitations for coverage months during such taxable  
22 year for each individual referred to in subsection (a)  
23 for whom the taxpayer paid during the taxable year  
24 any amount for coverage under qualified health in-  
25 surance.

1 “(2) MONTHLY LIMITATION.—

2 “(A) IN GENERAL.—The monthly limita-  
3 tion for an individual for each coverage month  
4 of such individual during the taxable year is the  
5 amount equal to 1/12 of—

6 “(i) \$1,000 if such individual is the  
7 taxpayer,

8 “(ii) \$1,000 if—

9 “(I) such individual is the spouse  
10 of the taxpayer,

11 “(II) the taxpayer and such  
12 spouse are married as of the first day  
13 of such month, and

14 “(III) the taxpayer files a joint  
15 return for the taxable year, and

16 “(iii) \$500 if such individual is an in-  
17 dividual for whom a deduction under sec-  
18 tion 151(c) is allowable to the taxpayer for  
19 such taxable year.

20 “(B) LIMITATION TO 2 DEPENDENTS.—  
21 Not more than 2 individuals may be taken into  
22 account by the taxpayer under subparagraph  
23 (A)(iii).

24 “(C) SPECIAL RULE FOR MARRIED INDI-  
25 VIDUALS.—In the case of an individual—

1           “(i) who is married (within the mean-  
 2           ing of section 7703) as of the close of the  
 3           taxable year but does not file a joint return  
 4           for such year, and

5           “(ii) who does not live apart from  
 6           such individual’s spouse at all times during  
 7           the taxable year,

8           the limitation imposed by subparagraph (B)  
 9           shall be divided equally between the individual  
 10          and the individual’s spouse unless they agree on  
 11          a different division.

12          “(3) COVERAGE MONTH.—For purposes of this  
 13          subsection—

14               “(A) IN GENERAL.—The term ‘coverage  
 15               month’ means, with respect to an individual,  
 16               any month if—

17                       “(i) as of the first day of such month  
 18                       such individual is covered by qualified  
 19                       health insurance, and

20                       “(ii) the premium for coverage under  
 21                       such insurance for such month is paid by  
 22                       the taxpayer.

23               “(B)       EMPLOYER-SUBSIDIZED       COV-  
 24               ERAGE.—

1           “(i) IN GENERAL.—Such term shall  
2           not include any month for which such indi-  
3           vidual is eligible to participate in any sub-  
4           sidized health plan (within the meaning of  
5           section 162(l)(2)) maintained by any em-  
6           ployer of the taxpayer or of the spouse of  
7           the taxpayer.

8           “(ii) PREMIUMS TO NONSUBSIDIZED  
9           PLANS.—If an employer of the taxpayer or  
10          the spouse of the taxpayer maintains a  
11          health plan which is not a subsidized  
12          health plan (as so defined) and which con-  
13          stitutes qualified health insurance, em-  
14          ployee contributions to the plan shall be  
15          treated as amounts paid for qualified  
16          health insurance.

17          “(C) CAFETERIA PLAN AND FLEXIBLE  
18          SPENDING ACCOUNT BENEFICIARIES.—Such  
19          term shall not include any month during a tax-  
20          able year if any amount is not includible in the  
21          gross income of the taxpayer for such year  
22          under section 106 with respect to—

23                 “(i) a benefit chosen under a cafeteria  
24                 plan (as defined in section 125(d)), or

1           “(ii) a benefit provided under a flexi-  
2           ble spending or similar arrangement.

3           “(D) MEDICARE AND MEDICAID.—Such  
4           term shall not include any month with respect  
5           to an individual if, as of the first day of such  
6           month, such individual—

7                   “(i) is entitled to any benefits under  
8                   title XVIII of the Social Security Act, or

9                   “(ii) is a participant in the program  
10                  under title XIX or XXI of such Act.

11           “(E) CERTAIN OTHER COVERAGE.—Such  
12           term shall not include any month during a tax-  
13           able year with respect to an individual if, at any  
14           time during such year, any benefit is provided  
15           to such individual under—

16                   “(i) chapter 89 of title 5, United  
17                   States Code,

18                   “(ii) chapter 55 of title 10, United  
19                   States Code,

20                   “(iii) chapter 17 of title 38, United  
21                   States Code, or

22                   “(iv) any medical care program under  
23                   the Indian Health Care Improvement Act.

24           “(F) PRISONERS.—Such term shall not in-  
25           clude any month with respect to an individual

1 if, as of the first day of such month, such indi-  
2 vidual is imprisoned under Federal, State, or  
3 local authority.

4 “(G) INSUFFICIENT PRESENCE IN UNITED  
5 STATES.—Such term shall not include any  
6 month during a taxable year with respect to an  
7 individual if such individual is present in the  
8 United States on fewer than 183 days during  
9 such year (determined in accordance with sec-  
10 tion 7701(b)(7)).

11 “(4) COORDINATION WITH DEDUCTION FOR  
12 HEALTH INSURANCE COSTS OF SELF-EMPLOYED IN-  
13 DIVIDUALS.—In the case of a taxpayer who is eligi-  
14 ble to deduct any amount under section 162(l) for  
15 the taxable year, this section shall apply only if the  
16 taxpayer elects not to claim any amount as a deduc-  
17 tion under such section for such year.

18 “(c) QUALIFIED HEALTH INSURANCE.—For pur-  
19 poses of this section—

20 “(1) IN GENERAL.—The term ‘qualified health  
21 insurance’ means insurance which constitutes med-  
22 ical care as defined in section 213(d) without regard  
23 to—

24 “(A) paragraph (1)(C) thereof, and

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

4           “(2) EXCLUSION OF CERTAIN OTHER CON-  
5           TRACTS.—Such term shall not include insurance if a  
6           substantial portion of its benefits are excepted bene-  
7           fits (as defined in section 9832(c)).

8           “(d) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
9           TIONS.—

10           “(1) IN GENERAL.—If a deduction would (but  
11           for paragraph (2)) be allowed under section 220 to  
12           the taxpayer for a payment for the taxable year to  
13           the medical savings account of an individual, sub-  
14           section (a) shall be applied by treating such payment  
15           as a payment for qualified health insurance for such  
16           individual.

17           “(2) DENIAL OF DOUBLE BENEFIT.—No deduc-  
18           tion shall be allowed under section 220 for that por-  
19           tion of the payments otherwise allowable as a deduc-  
20           tion under section 220 for the taxable year which is  
21           equal to the amount of credit allowed for such tax-  
22           able year by reason of this subsection.

23           “(e) SPECIAL RULES.—

24           “(1) COORDINATION WITH MEDICAL EXPENSE  
25           DEDUCTION.—The amount which would (but for this

1 paragraph) be taken into account by the taxpayer  
2 under section 213 for the taxable year shall be re-  
3 duced by the credit (if any) allowed by this section  
4 to the taxpayer for such year.

5 “(2) DENIAL OF CREDIT TO DEPENDENTS.—No  
6 credit shall be allowed under this section to any indi-  
7 vidual with respect to whom a deduction under sec-  
8 tion 151 is allowable to another taxpayer for a tax-  
9 able year beginning in the calendar year in which  
10 such individual’s taxable year begins.

11 “(3) INFLATION ADJUSTMENT.—In the case of  
12 any taxable year beginning in a calendar year after  
13 2002, each dollar amount contained in subsection  
14 (b)(2)(A) shall be increased by an amount equal  
15 to—

16 “(A) such dollar amount, multiplied by

17 “(B) the cost-of-living adjustment deter-  
18 mined under section 1(f)(3) for the calendar  
19 year in which the taxable year begins, deter-  
20 mined by substituting ‘calendar year 2001’ for  
21 ‘calendar year 1992’ in subparagraph (B)  
22 thereof.

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

1 (\$25 in the case of the dollar amount in subsection  
2 (b)(2)(A)(iii)).”

3 (b) MAINTENANCE OF EFFORT REQUIREMENT.—  
4 Section 162 of such Code (relating to trade or business  
5 expenses) is amended by redesignating subsection (p) as  
6 subsection (q) and by inserting after subsection (o) the  
7 following new subsection:

8 “(p) GROUP HEALTH PLAN MAINTENANCE OF EF-  
9 FORT.—No deduction shall be allowed under this chapter  
10 to an employer for any amount paid or incurred in connec-  
11 tion with a group health plan (as defined in subsection  
12 (n)(3)) for any taxable year in which occurs the date of  
13 introduction of the Fair Care for the Uninsured Act of  
14 2001 unless such plan remains in effect for at least 60  
15 months after the date of the enactment of such Act.”.

16 (c) INFORMATION REPORTING.—

17 (1) IN GENERAL.—Subpart B of part III of  
18 subchapter A of chapter 61 of such Code (relating  
19 to information concerning transactions with other  
20 persons) is amended by inserting after section  
21 6050S the following new section:

22 **“SEC. 6050T. RETURNS RELATING TO PAYMENTS FOR**  
23 **QUALIFIED HEALTH INSURANCE.**

24 “(a) IN GENERAL.—Any person who, in connection  
25 with a trade or business conducted by such person, re-

1 ceives payments during any calendar year from any indi-  
 2 vidual for coverage of such individual or any other indi-  
 3 vidual under creditable health insurance, shall make the  
 4 return described in subsection (b) (at such time as the  
 5 Secretary may by regulations prescribe) with respect to  
 6 each individual from whom such payments were received.

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

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

11 “(2) contains—

12 “(A) the name, address, and TIN of the  
 13 individual from whom payments described in  
 14 subsection (a) were received,

15 “(B) the name, address, and TIN of each  
 16 individual who was provided by such person  
 17 with coverage under creditable health insurance  
 18 by reason of such payments and the period of  
 19 such coverage, and

20 “(C) such other information as the Sec-  
 21 retary may reasonably prescribe.

22 “(c) CREDITABLE HEALTH INSURANCE.—For pur-  
 23 poses of this section, the term ‘creditable health insurance’  
 24 means qualified health insurance (as defined in section  
 25 35(c)) other than—

1           “(1) insurance under a subsidized group health  
2 plan maintained by an employer, or

3           “(2) to the extent provided in regulations pre-  
4 scribed by the Secretary, any other insurance cov-  
5 ering an individual if no credit is allowable under  
6 section 35 with respect to such coverage.

7           “(d) STATEMENTS TO BE FURNISHED TO INDIVID-  
8 UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
9 QUIRED.—Every person required to make a return under  
10 subsection (a) shall furnish to each individual whose name  
11 is required under subsection (b)(2)(A) to be set forth in  
12 such return a written statement showing—

13           “(1) the name and address of the person re-  
14 quired to make such return and the phone number  
15 of the information contact for such person,

16           “(2) the aggregate amount of payments de-  
17 scribed in subsection (a) received by the person re-  
18 quired to make such return from the individual to  
19 whom the statement is required to be furnished, and

20           “(3) the information required under subsection  
21 (b)(2)(B) with respect to such payments.

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

1       “(e) RETURNS WHICH WOULD BE REQUIRED TO BE  
2 MADE BY 2 OR MORE PERSONS.—Except to the extent  
3 provided in regulations prescribed by the Secretary, in the  
4 case of any amount received by any person on behalf of  
5 another person, only the person first receiving such  
6 amount shall be required to make the return under sub-  
7 section (a).”.

8           (2) ASSESSABLE PENALTIES.—

9           (A) Subparagraph (B) of section  
10       6724(d)(1) of such Code (relating to defini-  
11       tions) is amended by redesignating clauses (xi)  
12       through (xvii) as clauses (xii) through (xviii),  
13       respectively, and by inserting after clause (x)  
14       the following new clause:

15           “(xi) section 6050T (relating to re-  
16       turns relating to payments for qualified  
17       health insurance),”.

18           (B) Paragraph (2) of section 6724(d) of  
19       such Code is amended by striking “or” at the  
20       end of the next to last subparagraph, by strik-  
21       ing the period at the end of the last subpara-  
22       graph and inserting “, or”, and by adding at  
23       the end the following new subparagraph:

1           “(BB) section 6050T(d) (relating to re-  
2           turns relating to payments for qualified health  
3           insurance).”.

4           (3) CLERICAL AMENDMENT.—The table of sec-  
5           tions for subpart B of part III of subchapter A of  
6           chapter 61 of such Code is amended by inserting  
7           after the item relating to section 6050S the fol-  
8           lowing new item:

“Sec. 6050T. Returns relating to payments for qualified health  
insurance.”.

9           (d) CONFORMING AMENDMENTS.—

10           (1) Paragraph (2) of section 1324(b) of title  
11           31, United States Code, is amended by inserting be-  
12           fore the period “, or from section 35 of such Code”.

13           (2) The table of sections for subpart C of part  
14           IV of subchapter A of chapter 1 of such Code is  
15           amended by striking the last item and inserting the  
16           following new items:

“Sec. 35. Health insurance costs.

“Sec. 36. Overpayments of tax.”.

17           (e) EFFECTIVE DATE.—The amendments made by  
18           this section shall apply to taxable years beginning after  
19           December 31, 2001.

1 **SEC. 102. ADVANCE PAYMENT OF CREDIT FOR PUR-**  
 2 **CHASERS OF QUALIFIED HEALTH INSUR-**  
 3 **ANCE.**

4 (a) IN GENERAL.—Chapter 77 of the Internal Rev-  
 5 enue Code of 1986 (relating to miscellaneous provisions)  
 6 is amended by adding at the end the following new section:

7 **“SEC. 7527. ADVANCE PAYMENT OF HEALTH INSURANCE**  
 8 **CREDIT FOR PURCHASERS OF QUALIFIED**  
 9 **HEALTH INSURANCE.**

10 “(a) GENERAL RULE.—In the case of an eligible indi-  
 11 vidual, the Secretary shall make payments to the provider  
 12 of such individual’s qualified health insurance equal to  
 13 such individual’s qualified health insurance credit advance  
 14 amount with respect to such provider.

15 “(b) ELIGIBLE INDIVIDUAL.—For purposes of this  
 16 section, the term ‘eligible individual’ means any  
 17 individual—

18 “(1) who purchases qualified health insurance  
 19 (as defined in section 35(c)), and

20 “(2) for whom a qualified health insurance  
 21 credit eligibility certificate is in effect.

22 “(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGI-  
 23 BILITY CERTIFICATE.—For purposes of this section, a  
 24 qualified health insurance credit eligibility certificate is a  
 25 statement furnished by an individual to the Secretary  
 26 which—

1           “(1) certifies that the individual will be eligible  
2           to receive the credit provided by section 35 for the  
3           taxable year,

4           “(2) estimates the amount of such credit for  
5           such taxable year, and

6           “(3) provides such other information as the  
7           Secretary may require for purposes of this section.

8           “(d) QUALIFIED HEALTH INSURANCE CREDIT AD-  
9           VANCE AMOUNT.—For purposes of this section, the term  
10          ‘qualified health insurance credit advance amount’ means,  
11          with respect to any provider of qualified health insurance,  
12          the Secretary’s estimate of the amount of credit allowable  
13          under section 35 to the individual for the taxable year  
14          which is attributable to the insurance provided to the indi-  
15          vidual by such provider.

16          “(e) REGULATIONS.—The Secretary shall prescribe  
17          such regulations as may be necessary to carry out the pur-  
18          poses of this section.”.

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

                                  “Sec. 7527. Advance payment of health insurance credit for pur-  
  chasers of qualified health insurance.”.

22          (c) EFFECTIVE DATE.—The amendments made by  
23          this section shall take effect on January 1, 2002.

1 **TITLE II—ASSURING HEALTH IN-**  
2 **SURANCE COVERAGE FOR UN-**  
3 **INSURABLE INDIVIDUALS**

4 **SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE SAFETY**  
5 **NETS.**

6 (a) IN GENERAL.—

7 (1) REQUIREMENT.—For years beginning with  
8 2002, each health insurer, health maintenance orga-  
9 nization, and health service organization shall be a  
10 participant in a health insurance safety net (in this  
11 title referred to as a “safety net”) established by the  
12 State in which it operates.

13 (2) FUNCTIONS.—Any safety net shall assure,  
14 in accordance with this title, the availability of quali-  
15 fied health insurance coverage to uninsurable indi-  
16 viduals.

17 (3) FUNDING.—Any safety net shall be funded  
18 by an assessment against health insurers, health  
19 service organizations, and health maintenance orga-  
20 nizations on a pro rata basis of premiums collected  
21 in the State in which the safety net operates. The  
22 costs of the assessment may be added by a health  
23 insurer, health service organization, or health main-  
24 tenance organization to the costs of its health insur-  
25 ance or health coverage provided in the State.

1           (4) GUARANTEED RENEWABLE.—Coverage  
2 under a safety net shall be guaranteed renewable ex-  
3 cept for nonpayment of premiums, material mis-  
4 representation, fraud, medicare eligibility under title  
5 XVIII of the Social Security Act (42 U.S.C. 1395 et  
6 seq.), loss of dependent status, or eligibility for other  
7 health insurance coverage.

8           (5) COMPLIANCE WITH NAIC MODEL ACT.—In  
9 the case of a State that has not established, as of  
10 the date of the enactment of this Act, a high risk  
11 pool or other comprehensive health insurance pro-  
12 gram that assures the availability of qualified health  
13 insurance coverage to all eligible individuals residing  
14 in the State, a safety net shall be established in ac-  
15 cordance with the requirements of the “Model  
16 Health Plan For Uninsurable Individuals Act” (or  
17 the successor model Act), as adopted by the Na-  
18 tional Association of Insurance Commissioners and  
19 as in effect on the date of the safety net’s establish-  
20 ment.

21           (b) DEADLINE.—Safety nets required under sub-  
22 section (a) shall be established not later than January 1,  
23 2002.

24           (c) WAIVER.—This title shall not apply in the case  
25 of insurers and organizations operating in a State if the

1 State has established a similar comprehensive health in-  
 2 surance program that assures the availability of qualified  
 3 health insurance coverage to all eligible individuals resid-  
 4 ing in the State.

5 (d) RECOMMENDATION FOR COMPLIANCE REQUIRE-  
 6 MENT.—Not later than January 1, 2003, the Secretary  
 7 of Health and Human Services shall submit to Congress  
 8 a recommendation on appropriate sanctions for States  
 9 that fail to meet the requirement of subsection (a).

10 **SEC. 202. UNINSURABLE INDIVIDUALS ELIGIBLE FOR COV-**  
 11 **ERAGE.**

12 (a) UNINSURABLE AND ELIGIBLE INDIVIDUAL DE-  
 13 FINED.—In this title:

14 (1) UNINSURABLE INDIVIDUAL.—The term  
 15 “uninsurable individual” means, with respect to a  
 16 State, an eligible individual who presents proof of  
 17 uninsurability by a private insurer in accordance  
 18 with subsection (b) or proof of a condition previously  
 19 recognized as uninsurable by the State.

20 (2) ELIGIBLE INDIVIDUAL.—

21 (A) IN GENERAL.—The term “eligible indi-  
 22 vidual” means, with respect to a State, a citizen  
 23 or national of the United States (or an alien  
 24 lawfully admitted for permanent residence) who  
 25 is a resident of the State for at least 90 days

1 and includes any dependent (as defined for pur-  
2 poses of the Internal Revenue Code of 1986)  
3 of such a citizen, national, or alien who also is  
4 such a resident.

5 (B) EXCEPTION.—An individual is not an  
6 “eligible individual” if the individual—

7 (i) is covered by or eligible for benefits  
8 under a State medicaid plan approved  
9 under title XIX of the Social Security Act  
10 (42 U.S.C. 1396 et seq.),

11 (ii) has voluntarily terminated safety  
12 net coverage within the past 6 months,

13 (iii) has received the maximum benefit  
14 payable under the safety net,

15 (iv) is an inmate in a public institu-  
16 tion, or

17 (v) is eligible for other public or pri-  
18 vate health care programs (including pro-  
19 grams that pay for directly, or reimburse,  
20 otherwise eligible individuals with pre-  
21 miums charged for safety net coverage).

22 (b) PROOF OF UNINSURABILITY.—

23 (1) IN GENERAL.—The proof of uninsurability  
24 for an individual shall be in the form of—

1 (A) a notice of rejection or refusal to issue  
2 substantially similar health insurance for health  
3 reasons by one insurer; or

4 (B) a notice of refusal by an insurer to  
5 issue substantially similar health insurance ex-  
6 cept at a rate in excess of the rate applicable  
7 to the individual under the safety net plan.

8 For purposes of this paragraph, the term “health in-  
9 surance” does not include insurance consisting only  
10 of stoploss, excess of loss, or reinsurance coverage.

11 (2) EXCEPTION FOR INDIVIDUALS WITH UNIN-  
12 SURABLE CONDITIONS.—The State shall promulgate  
13 a list of medical or health conditions for which an  
14 individual shall be eligible for safety net plan cov-  
15 erage without applying for health insurance or estab-  
16 lishing proof of uninsurability under paragraph (1).  
17 Individuals who can demonstrate the existence or  
18 history of any medical or health conditions on such  
19 list shall not be required to provide the proof de-  
20 scribed in paragraph (1). The list shall be effective  
21 on the first day of the operation of the safety net  
22 plan and may be amended from time to time as may  
23 be appropriate.

1 **SEC. 203. QUALIFIED HEALTH INSURANCE COVERAGE**  
2 **UNDER SAFETY NET.**

3 In this title, the term “qualified health insurance cov-  
4 erage” means, with respect to a State, health insurance  
5 coverage that provides benefits typical of major medical  
6 insurance available in the individual health insurance mar-  
7 ket in such State.

8 **SEC. 204. FUNDING OF SAFETY NET.**

9 (a) **LIMITATIONS ON PREMIUMS.—**

10 (1) **IN GENERAL.—**The premium established  
11 under a safety net may not exceed 125 percent of  
12 the applicable standard risk rate, except as provided  
13 in paragraph (2).

14 (2) **SURCHARGE FOR AVOIDABLE HEALTH**  
15 **RISKS.—**A safety net may impose a surcharge on  
16 premiums for individuals with avoidable high risks,  
17 such as smoking.

18 (b) **ADDITIONAL FUNDING.—**A safety net shall pro-  
19 vide for additional funding through an assessment on all  
20 health insurers, health service organizations, and health  
21 maintenance organizations in the State through a non-  
22 profit association consisting of all such insurers and orga-  
23 nizations doing business in the State on an equitable and  
24 pro rata basis consistent with section 201.

1 **SEC. 205. ADMINISTRATION.**

2 A safety net in a State shall be administered through  
3 a contract with 1 or more insurers or third party adminis-  
4 trators operating in the State.

5 **SEC. 206. AUTHORIZATION OF APPROPRIATIONS.**

6 There are authorized to be appropriated such sums  
7 as may be necessary to reimburse States for their costs  
8 in administering this title.

9 **TITLE III—INDIVIDUAL**  
10 **MEMBERSHIP ASSOCIATIONS**

11 **SEC. 301. EXPANSION OF ACCESS AND CHOICE THROUGH**

12 **INDIVIDUAL MEMBERSHIP ASSOCIATIONS**

13 **(IMAs).**

14 The Public Health Service Act is amended by adding  
15 at the end the following new title:

16 “TITLE XXVIII—INDIVIDUAL MEMBERSHIP

17 ASSOCIATIONS

18 “SEC. 2801. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-

19 SOCIATION (IMA).

20 “(a) IN GENERAL.—For purposes of this title, the  
21 terms ‘individual membership association’ and ‘IMA’  
22 mean a legal entity that meets the following requirements:

23 “(1) ORGANIZATION.—The IMA is an organiza-  
24 tion operated under the direction of an association  
25 (as defined in section 2804(1)).

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

3           “(A) DIFFERENT GROUPS.—The IMA, in  
4 conjunction with those health insurance issuers  
5 that offer health benefits coverage through the  
6 IMA, makes available health benefits coverage  
7 in the manner described in subsection (b) to all  
8 members of the IMA and the dependents of  
9 such members in the manner described in sub-  
10 section (c)(2) at rates that are established by  
11 the health insurance issuer on a policy or prod-  
12 uct specific basis and that may vary only as  
13 permissible under State law.

14           “(B) NONDISCRIMINATION IN COVERAGE  
15 OFFERED.—

16           “(i) IN GENERAL.—Subject to clause  
17 (ii), the IMA may not offer health benefits  
18 coverage to a member of an IMA unless  
19 the same coverage is offered to all such  
20 members of the IMA.

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

1 preventing a health insurance issuer from  
2 excluding or limiting the coverage on any  
3 individual, subject to the requirement of  
4 section 2741.

5 “(C) NO FINANCIAL UNDERWRITING.—The  
6 IMA provides health benefits coverage only  
7 through contracts with health insurance issuers  
8 and does not assume insurance risk with re-  
9 spect to such coverage.

10 “(3) GEOGRAPHIC AREAS.—Nothing in this title  
11 shall be construed as preventing the establishment  
12 and operation of more than one IMA in a geographic  
13 area or as limiting the number of IMAs that may  
14 operate in any area.

15 “(4) PROVISION OF ADMINISTRATIVE SERVICES  
16 TO PURCHASERS.—

17 “(A) IN GENERAL.—The IMA may provide  
18 administrative services for members. Such serv-  
19 ices may include accounting, billing, and enroll-  
20 ment information.

21 “(B) CONSTRUCTION.—Nothing in this  
22 subsection shall be construed as preventing an  
23 IMA from serving as an administrative service  
24 organization to any entity.

1           “(5) FILING INFORMATION.—The IMA files  
2 with the Secretary information that demonstrates  
3 the IMA’s compliance with the applicable require-  
4 ments of this title.

5           “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
6 MENTS.—

7           “(1) COMPLIANCE WITH CONSUMER PROTEC-  
8 TION REQUIREMENTS.—Any health benefits coverage  
9 offered through an IMA shall—

10                   “(A) be underwritten by a health insurance  
11 issuer that—

12                           “(i) is licensed (or otherwise regu-  
13 lated) under State law,

14                           “(ii) meets all applicable State stand-  
15 ards relating to consumer protection, sub-  
16 ject to section 2802(2), and

17                           “(iii) offers the coverage under a con-  
18 tract with the IMA; and

19                   “(B) subject to paragraph (2) and section  
20 2902(2), be approved or otherwise permitted to  
21 be offered under State law.

22           “(2) EXAMPLES OF TYPES OF COVERAGE.—The  
23 benefits coverage made available through an IMA  
24 may include, but is not limited to, any of the fol-

1       lowing if it meets the other applicable requirements  
2       of this title:

3               “(A) Coverage through a health mainte-  
4               nance organization.

5               “(B) Coverage in connection with a pre-  
6               ferred provider organization.

7               “(C) Coverage in connection with a li-  
8               censed provider-sponsored organization.

9               “(D) Indemnity coverage through an insur-  
10              ance company.

11              “(E) Coverage offered in connection with a  
12              contribution into a medical savings account or  
13              flexible spending account.

14              “(F) Coverage that includes a point-of-  
15              service option.

16              “(G) Any combination of such types of  
17              coverage.

18              “(3) HEALTH INSURANCE COVERAGE OP-  
19              TIONS.—An IMA shall include a minimum of 2  
20              health insurance coverage options. At least 1 option  
21              shall meet all applicable State benefit mandates.

22              “(4) WELLNESS BONUSES FOR HEALTH PRO-  
23              MOTION.—Nothing in this title shall be construed as  
24              precluding a health insurance issuer offering health  
25              benefits coverage through an IMA from establishing

1 premium discounts or rebates for members or from  
2 modifying otherwise applicable copayments or  
3 deductibles in return for adherence to programs of  
4 health promotion and disease prevention so long as  
5 such programs are agreed to in advance by the IMA  
6 and comply with all other provisions of this title and  
7 do not discriminate among similarly situated mem-  
8 bers.

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

10 “(1) MEMBERS.—

11 “(A) IN GENERAL.—Under rules estab-  
12 lished to carry out this title, with respect to an  
13 individual who is a member of an IMA, the in-  
14 dividual may apply for health benefits coverage  
15 (including coverage for dependents of such indi-  
16 vidual) offered by a health insurance issuer  
17 through the IMA.

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

1           “(2) HEALTH INSURANCE ISSUERS.—The con-  
2           tract between an IMA and a health insurance issuer  
3           shall provide, with respect to a member enrolled with  
4           health benefits coverage offered by the issuer  
5           through the IMA, for the payment of the premiums  
6           collected by the issuer.

7   **“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
8                           **MENTS.**

9           “State laws insofar as they relate to any of the fol-  
10          lowing are superseded and shall not apply to health bene-  
11          fits coverage made available through an IMA:

12                  “(1) Benefit requirements for health benefits  
13                  coverage offered through an IMA, including (but not  
14                  limited to) requirements relating to coverage of spe-  
15                  cific providers, specific services or conditions, or the  
16                  amount, duration, or scope of benefits, but not in-  
17                  cluding requirements to the extent required to imple-  
18                  ment title XXVII or other Federal law and to the  
19                  extent the requirement prohibits an exclusion of a  
20                  specific disease from such coverage.

21                  “(2) Any other requirements (including limita-  
22                  tions on compensation arrangements) that, directly  
23                  or indirectly, preclude (or have the effect of pre-  
24                  cluding) the offering of such coverage through an

1 IMA, if the IMA meets the requirements of this  
2 title.

3 Any State law or regulation relating to the composition  
4 or organization of an IMA is preempted to the extent the  
5 law or regulation is inconsistent with the provisions of this  
6 title.

7 **“SEC. 2803. ADMINISTRATION.**

8 “(a) IN GENERAL.—The Secretary shall administer  
9 this title and is authorized to issue such regulations as  
10 may be required to carry out this title. Such regulations  
11 shall be subject to Congressional review under the provi-  
12 sions of chapter 8 of title 5, United States Code. The Sec-  
13 retary shall incorporate the process of ‘deemed file and  
14 use’ with respect to the information filed under section  
15 2801(a)(5)(A) and shall determine whether information  
16 filed by an IMA demonstrates compliance with the applica-  
17 ble requirements of this title. The Secretary shall exercise  
18 authority under this title in a manner that fosters and  
19 promotes the development of IMAs in order to improve  
20 access to health care coverage and services.

21 “(b) PERIODIC REPORTS.—The Secretary shall sub-  
22 mit to Congress a report every 30 months, during the 10-  
23 year period beginning on the effective date of the rules  
24 promulgated by the Secretary to carry out this title, on  
25 the effectiveness of this title in promoting coverage of un-

1 insured individuals. The Secretary may provide for the  
2 production of such reports through one or more contracts  
3 with appropriate private entities.

4 **“SEC. 2804. DEFINITIONS.**

5 “For purposes of this title:

6 “(1) ASSOCIATION.—The term ‘association’  
7 means, with respect to health insurance coverage of-  
8 fered in a State, an association which—

9 “(A) has been actively in existence for at  
10 least 5 years;

11 “(B) has been formed and maintained in  
12 good faith for purposes other than obtaining in-  
13 surance;

14 “(C) does not condition membership in the  
15 association on any health status-related factor  
16 relating to an individual (including an employee  
17 of an employer or a dependent of an employee);  
18 and

19 “(D) does not make health insurance cov-  
20 erage offered through the association available  
21 other than in connection with a member of the  
22 association.

23 “(2) DEPENDENT.—The term ‘dependent’, as  
24 applied to health insurance coverage offered by a  
25 health insurance issuer licensed (or otherwise regu-

1       lated) in a State, shall have the meaning applied to  
2       such term with respect to such coverage under the  
3       laws of the State relating to such coverage and such  
4       an issuer. Such term may include the spouse and  
5       children of the individual involved.

6               “(3) HEALTH BENEFITS COVERAGE.—The term  
7       ‘health benefits coverage’ has the meaning given the  
8       term health insurance coverage in section  
9       2791(b)(1).

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

13              “(5) HEALTH STATUS-RELATED FACTOR.—The  
14       term ‘health status-related factor’ has the meaning  
15       given such term in section 2791(d)(9).

16              “(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIA-  
17       TION.—The terms ‘IMA’ and ‘individual membership  
18       association’ are defined in section 2801(a).

19              “(7) MEMBER.—The term ‘member’ means,  
20       with respect to an IMA, an individual who is a mem-  
21       ber of the association to which the IMA is offering  
22       coverage.”.

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