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109TH CONGRESS
1ST SESSION

H. R. 2203

To amend the Internal Revenue Code of 1986 to allow individuals a refundable and advancable credit against income tax for health insurance costs, to allow employees who elect not to participate in employer subsidized health plans an exclusion from gross income for employer payments in lieu of such participation, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 5, 2005

Mr. SHADEGG introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable and advancable credit against income tax for health insurance costs, to allow employees who elect not to participate in employer subsidized health plans an exclusion from gross income for employer payments in lieu of such participation, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Health Care Reform Act''.

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

(c) CONSTITUTIONAL AUTHORITY TO ENACT THIS LEGISLATION.—The constitutional authority upon which

this Act rests is the power of Congress to regulate commerce with foreign nations and among the several States, set forth in article I, section 8 of the United States Constitution.

SEC. 2. FINDINGS.

(a) NEED FOR STRUCTURAL REFORMS.—Congress finds that the majority of Americans are receiving health care of a quality unmatched elsewhere in the world but that the method by which health care currently is financed and delivered is inflationary and does not distribute quality care to all Americans. Congress further finds that the major structural reforms must be implemented in order to institute a competitive system based on individual choice, under which each American is permitted individual choice to select the method of health care delivery which he believes is most appropriate for himself and his family, with appropriate assistance from the United States Government. Such a system would introduce internal incentives for the cost-effective delivery of quality health care to the American people.

(b) SPECIFIC DEFICIENCIES.—Congress finds that the major deficiencies of the present method of delivering and financing health care as follows:

(1) EMPLOYER OWNERSHIP OF HEALTH BENEFITS.—The biggest problem with health care today

is that the tax code has encouraged employers, not individuals, to become the purchaser of health insurance. Employers have a tax incentive to offer health care benefits to their employees, which means that employers are truly the owner of the plan, not individuals. Therefore employees, who are the consumers of health care services are unconcerned with and not involved with issues of cost and overutilize health care services in the belief that such services are ''free''.

(2) INSUFFICIENT ACCESS.—Numerous persons are not able to obtain sufficient health care either because the necessary personnel and facilities are not located in their communities or because they do not have adequate financial resources to obtain such services, or both.

(3) EXCESSIVE GOVERNMENT REGULATION.—Continually increasing and complex Government regulation of the economic aspects of the health care delivery system has proven ineffective in restraining costs and is itself expensive and counterproductive in fulfilling its purposes and detrimental to the care of patients.

(4) THIRD-PARTY PAYMENT SYSTEMS.—Payment by third-party payers (including commercial in-

surance companies and various levels of government) for the preponderance of the health care delivered each year insulates patients, as well as physicians, hospitals, and other deliverers of health care, from the need to consider the cost of treatment in addition to the medical benefit expected from it.

(5) REASONABLE COST REIMBURSEMENT.—Reimbursement of hospitals and other health care institutions by third-party payers on the basis of reasonable costs of operation provides these institutions insufficient incentives to introduce more efficient methods of delivering care and at the same time diminishes the extent to which these institutions and their patients are affected by the consequences of inefficiency and overexpansion.

(6) GOVERNMENT AND THIRD-PARTY PAYER.—The present role of government as a third-party payer poses a conflict of interest whereby the Government purchases or finances health care services and unilaterally determines the amount the deliverer will be paid for those services.

(7) LACK OF COMPETITION.—The present system of financing and regulation prevents health care deliverers from competing with each other on the basis of efficiency and price as well as quality.

SEC. 3. PURPOSES.

The purposes of Act are—

(1) to make it possible for individuals, employees, and the self-employed to purchase and own their own health insurance without suffering any negative tax consequences;

(2) to enable individuals to make their own informed choice of the method by which their health care is provided, the persons who deliver it, and the price they wish to pay for it;

(3) to assist individuals in obtaining and in paying for basic health care services;

(4) to render patients and deliverers sensitive to the cost of health care, giving them both the incentive and the ability to restrain undesired increases in health care costs;

(5) to simplify and rationalize the payment mechanism for health care services;

(6) to foster the development of numerous, varied, and innovative systems of providing health care which will compete against each other in terms of price, service, and quality, and thus allow the American people to benefit from competitive forces which will reward efficient and effective deliverers and eliminate those which provide unsatisfactory quality of care or are inefficient;

(7) to replace governmental regulation of the economic aspects of health care delivery with individual choice, private initiative, and marketplace incentives and disciplines;

(8) to encourage the development of systems of delivering health care which are capable of supplying a broad range of health care services in a comprehensive and systematic manner, and

(9) to preserve the independence of health care deliverers and encourage their close identification with and their accountability to the individuals they serve.

TITLE I—HEALTHMARTS

SEC. 101. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

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

"TITLE XXIX—HEALTHMARTS

"SEC. 2901. DEFINITION OF HEALTHMART.

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is an organization operated under the direction of a board

of directors which is composed of representatives of not fewer than 2 from each of the following:

''(A) Employers.

''(B) Employees.

''(C) Individuals (other than those described in subparagraph (B)) who are eligible to participate in the HealthMart.

''(D) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

''(E) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) DIFFERENT GROUPS.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all employers, eligible employees, and individuals in the manner

described in subsection (c)(2) at rates (including employer's and employee's share, if applicable) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

''(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee or individual in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees or individuals in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain

eligible individuals under health benefits coverage in the small group market.

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

''(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

''(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to employers, or individuals, as the case may be. Any such area shall encompass at least one entire county or equivalent area.

"(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

"(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

"(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

"(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

"(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges

for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2903(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law,

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2902(b), and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act,

so long as both employers are purchasers in the HealthMart, and notwithstanding that they terminate such employment, if the HealthMart permits enrollment directly by eligible individuals.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2902).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or

product of health benefits coverage are as follows:

"(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

"(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

"(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any

requirements that are preempted under section 2902; or

"(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

"(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to re-

view and process applications for waivers under subparagraph (A).

''(3) EXAMPLES OF TYPES OF COVERAGE.—The benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

''(C) Coverage in connection with a licensed provider-sponsored organization.

''(D) Indemnity coverage through an insurance company.

''(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

''(F) Coverage that includes a point-of-service option.

''(G) Any combination of such types of coverage.

''(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health

benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

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

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any employer or any individual described in subsection (a)(1)(C) to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees or for the individual (and the individual's dependents), respectively, and may not vary conditions of eligibility (including premium rates and membership fees) of an employer or individual to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—

Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or employers or individuals from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 24 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 24-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 24 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—

''(i) IN GENERAL.—Subject to clause (ii), such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart.

''(ii) EXCEPTION IF NO COVERAGE OFFERED IN AREA OF RESIDENCES.—Clause (i) shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(iii) NOTHING PRECLUDING INDIVIDUAL EMPLOYEE OPT-OUT.—Nothing in this subparagraph shall be construed as requiring an eligible employee of a large or small employer that is a purchaser to obtain health benefits coverage through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—

''(i) EMPLOYMENT BASED MEMBERSHIP.—Under rules established to carry out this title, with respect to an employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

"(ii) INDIVIDUALS.—Under rules established to carry out this title, with respect to an individual who has a purchaser contract with a HealthMart for himself or herself, the individual may enroll for health benefits coverage (including coverage for dependents of such individual) offered by a health insurance issuer through the HealthMart.

"(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee or individual (or dependent of such an employee or individual) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

"(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change

the coverage option in which the members are enrolled.

''(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee or individual eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

"(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

"(C) AVAILABILITY OF COVERAGE OPTIONS.—

"(i) IN GENERAL.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available.

"(ii) REQUIREMENT OF NON-NETWORK OPTION.—At least one of the health insurance coverage options made available under clause (i) shall be a non-network coverage option under which enrollees may obtain benefits for health care items and services that are not provided under a contract between the provider of the service and the issuer involved.

"(d) PREVENTION OF CONFLICTS OF INTEREST.—

"(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not

serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2901(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term 'affiliated' does not

include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

''(i) a change of employers through which the coverage is provided, or

''(ii) a change in place of employment to an area not served by the previous HealthMart.

''(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''SEC. 2902. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

''(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

''(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

''(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

''(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

''(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of pre-

cluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees enrolled on the basis of employment shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents)

all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

''SEC. 2903. ADMINISTRATION.

''(a) IN GENERAL.—The applicable Federal authority shall administer this title and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2901(a)(6)(A) and shall determine whether information filed by a HealthMart dem-

onstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

''(b) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

''SEC. 2904. DEFINITIONS.

''For purposes of this title:

''(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services .

''(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2901(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

''(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer. The term 'dependent' may include the spouse and children of the individual involved.

''(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4).

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

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

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2901(a).

''(8) MEMBER.—The term 'member'' means, with respect to a HealthMart, an individual enrolled

for health benefits coverage through the HealthMart under section 2901(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, an employer or individual that has contracted under section 2901(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.''.

TITLE II—HEALTH CARE ACCESS AND CHOICE THROUGH INDIVIDUAL MEMBERSHIP ASSOCIATIONS (IMAS)

SEC. 201. EXPANSION OF ACCESS AND CHOICE THROUGH INDIVIDUAL MEMBERSHIP ASSOCIATIONS (IMAS).

The Public Health Service Act, as amended by section 101, is further amended by adding at the end the following new title:

''TITLE XXX—INDIVIDUAL MEMBERSHIP ASSOCIATIONS

''SEC. 3001. DEFINITION OF INDIVIDUAL MEMBERSHIP ASSOCIATION (IMA).

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

''(1) ORGANIZATION.—The IMA is an organization operated under the direction of an association (as defined in section 3004(1)).

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) DIFFERENT GROUPS.—The IMA, in conjunction with those health insurance issuers that offer health benefits coverage through the IMA, makes available health benefits coverage in the manner described in subsection (b) to all members of the IMA and the dependents of such members in the manner described in subsection (c)(2) at rates that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law.

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

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

''(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or

permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law, or requiring a health insurance issuer from excluding or limiting the coverage on any individual, subject to the requirement of section 2741.

''(C) NO FINANCIAL UNDERWRITING.—The IMA provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

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

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The IMA may provide administrative services for members. Such services may include accounting, billing, and enrollment information.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an

IMA from serving as an administrative service organization to any entity.

''(5) FILING INFORMATION.—The IMA files with the Secretary information that demonstrates the IMA's compliance with the applicable requirements of this title.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through an IMA shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law,

''(ii) meets all applicable State standards relating to consumer protection, subject to section 3002(b), and

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law.

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

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

"(A) Coverage through a health maintenance organization.

"(B) Coverage in connection with a preferred provider organization.

"(C) Coverage in connection with a licensed provider-sponsored organization.

"(D) Indemnity coverage through an insurance company.

"(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

"(F) Coverage that includes a point-of-service option.

"(G) Any combination of such types of coverage.

"(3) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through an IMA from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as

such programs are agreed to in advance by the IMA and comply with all other provisions of this title and do not discriminate among similarly situated members.

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

''(1) MEMBERS.—

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

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

''(2) HEALTH INSURANCE ISSUERS.—The contract between an IMA and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer

through the IMA, for the payment of the premiums collected by the issuer.

"SEC. 3002. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

"State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through an IMA:

"(1) Benefit requirements for health benefits coverage offered through an IMA, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

"(2) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through an IMA, if the IMA meets the requirements of this title.

Any State law or regulation relating to the composition or organization of an IMA is preempted to the extent the

law or regulation is inconsistent with the provisions of this title.

"SEC. 3003. ADMINISTRATION.

"(a) IN GENERAL.—The Secretary shall administer this title and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The Secretary shall incorporate the process of 'deemed file and use' with respect to the information filed under section 3001(a)(5)(A) and shall determine whether information filed by an IMA demonstrates compliance with the applicable requirements of this title. The Secretary shall exercise authority under this title in a manner that fosters and promotes the development of IMAs in order to improve access to health care coverage and services.

"(b) PERIODIC REPORTS.—The Secretary shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the Secretary to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. The Secretary may provide for the production of such reports through one or more contracts with appropriate private entities.

"SEC. 3004. DEFINITIONS.

''For purposes of this title:

''(1) ASSOCIATION.—The term 'association' means, with respect to health insurance coverage offered in a State, an association which—

''(A) has been actively in existence for at least 5 years;

''(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

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

''(D) does not make health insurance coverage offered through the association available other than in connection with a member of the association.

''(2) DEPENDENT.—The term 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meaning applied to such term with respect to such coverage under the laws of the State relating to such coverage and such

an issuer. Such term may include the spouse and children of the individual involved.

''(3) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term health insurance coverage in section 2791(b)(1).

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

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

''(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIATION.—The terms 'IMA' and 'individual membership association' are defined in section 3001(a).

''(7) MEMBER.—The term 'member' means, with respect to an IMA, an individual who is a member of the association to which the IMA is offering coverage.''.

TITLE III—FEDERAL MATCHING FUNDING FOR STATE INSURANCE EXPENDITURES

SEC. 301. FEDERAL MATCHING FUNDING FOR STATE INSURANCE EXPENDITURES.

(a) IN GENERAL.—Subject to the succeeding provisions of this section, each State shall receive from the Secretary of Health and Human Services an amount equal to 50 percent of the funds expended by the State in providing for the use, in connection with providing health benefits coverage, of a high-risk pool, a reinsurance pool, or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of private health insurance.

(b) FUNDING LIMITATION.—A State shall not receive under this section for a fiscal year more than a total of 50 cents multiplied by the average number of residents (as estimated by the Secretary) in the State in the fiscal year.

(c) ADMINISTRATION.—The Secretary of Health and Human Services shall provide for the administration of this section and may establish such terms and conditions, including the requirement of an application, as may be appropriate to carry out this section.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring a State to operate a reinsurance

pool (or other risk-adjustment mechanism) under this section or as preventing a State from operating such a pool or mechanism through one or more private entities.

(e) HIGH-RISK POOL.—For purposes of this section, the term ''high-risk pool'' means any qualified high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

(f) REINSURANCE POOL OR OTHER RISK-ADJUSTMENT MECHANISM DEFINED.—For purposes of this section, the term ''reinsurance pool or other risk-adjustment mechanism'' means any State-based risk spreading mechanism to subsidize the purchase of private health insurance for the high-risk population.

(g) HIGH-RISK POPULATION.—For purposes of this section, the term ''high-risk population'' means—

(1) individuals who, by reason of the existence or history of a medical condition, are able to acquire health coverage only at rates which are at least 150 percent of the standard risk rates for such coverage, and

(2) individuals who are provided health coverage by a high-risk pool.

(h) STATE DEFINED.—For purposes of this section, the term ''State'' includes the District of Columbia, Puer-

to Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

TITLE IV—AFFORDABLE HEALTH COVERAGE FOR EMPLOYEES OF SMALL BUSINESSES

SEC. 401. SHORT TITLE OF TITLE.

This title may be cited as the ''Small Business Access and Choice for Entrepreneurs Act of 2005''.

SEC. 402. RULES.

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

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

''(1) whose sponsor is (or is deemed under this part to be) described in subsection (b); and

''(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to partici-

pants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

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

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

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

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

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

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the re-

quirements of this part only if the applicable authority is satisfied that—

"(1) such certification—

"(A) is administratively feasible;

"(B) is not adverse to the interests of the individuals covered under the plan; and

"(C) is protective of the rights and benefits of the individuals covered under the plan; and

"(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

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

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

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

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

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

''(1) a plan which offered such coverage on the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005,

''(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

''(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State

rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plan in accordance with regulations which the Secretary shall prescribe through negotiated rulemaking, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

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

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

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or

employee of, or partner in, a contract administrator or other service provider to the plan.

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

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

''(C) CERTAIN PLANS EXCLUDED.—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of

the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005.

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

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

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

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

The Secretary may by regulation, through negotiated rulemaking, define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met;

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met; and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan; or

''(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met;

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Busi-

ness Access and Choice for Entrepreneurs Act of 2005, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

''(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

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

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

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

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

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan in-

clude a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

"(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

"(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

"(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

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

connection with an association health plan, from—

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

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

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

"(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

"(4) MARKETING REQUIREMENTS.—

"(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is

offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

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

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

''(b) HEALTH BENEFIT OPTIONS UNDER AN ASSOCIATION HEALTH PLAN.—

''(1) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through an association health plan may include, but is not lim-

ited to, any of the following if it meets the other applicable requirements of this title:

"(A) Coverage through a health maintenance organization.

"(B) Coverage in connection with a preferred provider organization.

"(C) Coverage in connection with a licensed provider-sponsored organization.

"(D) Indemnity coverage through an insurance company.

"(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

"(F) Coverage that includes a point-of-service option.

"(G) Any combination of such types of coverage.

"(2) HEALTH INSURANCE COVERAGE OPTIONS.—

"(A) IN GENERAL.—An association health plan shall include a minimum of 4 health insurance coverage options. At least 1 option shall be a non network option. At least 2 options shall meet all applicable State benefit mandates.

''(B) MODEL BENEFITS PACKAGE.—The Secretary in consultation with the National Association of Insurance Commissioners shall develop a model benefits package for health insurance coverage not later than one year after the date of the enactment of the Consensus Health Care Access and Choice Act of 2003.

''(C) EXCEPTION TO GENERAL RULE.—An association health plan may offer 2 options that meet the requirements of the model benefits package in lieu of the State benefit mandate offerings required under subparagraph (A).

''(3) PERMITTING ASSOCIATION HEALTH PLANS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding an association health plan from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the association health plan based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''(4) CONSTRUCTION.—Except as provided in subparagraph (2), nothing in this part or any provision of State law (as defined in section 514(c)(1))

shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

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

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

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

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

''(A) establishes and maintains reserves with respect to such additional benefit options,

in amounts recommended by the qualified actuary, consisting of—

"(i) a reserve sufficient for unearned contributions;

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

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

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

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

"(i) The plan shall secure aggregate excess /stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross

annual claims. The applicable authority may by regulation, through negotiated rulemaking, provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess /stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $175,000). The applicable authority may by regulation, through negotiated rulemaking, provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

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

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

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

''(1) $500,000, or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority through negotiated rulemaking, based on the level of aggregate and specific excess /stop loss insurance provided with respect to such plan.

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

negotiated rulemaking, with respect to any such plan or any class of such plans.

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

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

of participating employers, security, or other financial arrangement.

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

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

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

"(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a

plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

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

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

erage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

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

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

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

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

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

''(B) which is guaranteed renewable; and

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

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

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan

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

''(B) which is guaranteed renewable; and

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

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

''(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

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

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

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe through negotiated rulemaking.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

''(A) a representative of the National Association of Insurance Commissioners;

''(B) a representative of the American Academy of Actuaries;

''(C) a representative of the State governments, or their interests;

''(D) a representative of existing self-insured arrangements, or their interests;

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

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

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

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

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

be prescribed by the applicable authority through negotiated rulemaking, at least the following information:

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

''(A) the sponsor; and

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

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

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

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

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

plan and contract administrators and other service providers.

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

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

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

such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

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

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

''(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation through nego-

tiated rulemaking, as necessary to carry out the purposes of this part.

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

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

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan

certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation through negotiated rulemaking such interim reports as it considers appropriate.

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

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

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

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

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

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

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation through negotiated rulemaking.

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may

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

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

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

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

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the

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

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

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

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

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

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

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

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

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to fur-

nish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

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

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

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

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

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

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

pants and beneficiaries and providers of medical care.

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

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

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

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

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

''(f) JURISDICTION OF COURT.—

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

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

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

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005.

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

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

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

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

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

nance organizations in such State in connection with such plan.

"SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

"(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

"(b) EFFECT OF ELECTION.—

"(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church

plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such

provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) STATE LAW.—The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

''(A) for the exclusive purpose of:

"(i) providing benefits to participants and their beneficiaries; and

"(ii) defraying reasonable expenses of administering the plan;

"(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

"(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

"(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

"(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, writ-

ten in a manner calculated to be understood by the participant;

"(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

"(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

"(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

"(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

"(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

"(C) identifying the States in which participants and beneficiaries under the plan are or

likely will be located during the 1-year period covered by the statement; and

"(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

"(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

"(d) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement

of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(e) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

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

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section

733(a)(1) (after applying subsection (b) of this section).

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

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

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

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan; or

''(ii) if there is no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

''(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section

809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

''(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 806(j), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

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

"(7) INDIVIDUAL MARKET.—

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

"(B) TREATMENT OF VERY SMALL GROUPS.—

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

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

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

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

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

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the

Secretary may provide by regulation through negotiated rulemaking.

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

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

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

''(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005, a person eligible to be a member of the sponsor or one of its member associations.

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

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

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

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

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

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was estab-

lished or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

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

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

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

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

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

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws

of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

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

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

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'par-

ticipating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

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

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

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

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

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

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

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

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

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

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

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

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2010, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

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

SEC. 403. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

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

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

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

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

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 per-

cent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement;''.

SEC. 404. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E);''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or

maintained in accordance with this subparagraph only if the following requirements are met:

"(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

"(II) pay any type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations prescribed by the Secretary through negotiated rulemaking), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely

of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement

with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2003 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed by the Secretary through negotiated rulemaking that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Access and Choice for Entrepreneurs Act of 2005; or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years; or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an indi-

vidual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 405. ENFORCEMENT PROVISIONS.

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

(1) by inserting ''(a)'' after ''Sec. 501.''; and

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

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

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

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

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

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

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

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

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

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

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification, a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

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

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

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

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

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

(1) by inserting ''(a) In General.—'' after ''Sec. 503.''; and

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

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

SEC. 406. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

''(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

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

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

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

''(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 407. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 101, 104, and 105 shall take effect on January 1, 2007. The amendments made by sections 102 and 103 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle before January 1, 2007. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 101) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on the date of the enactment of this Act, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make

contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

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

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

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

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

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

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE V—IMPROVEMENT TO ACCESS AND CHOICE OF HEALTH CARE

SEC. 501. REFUNDABLE AND ADVANCEABLE CREDIT FOR HEALTH INSURANCE COSTS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. HEALTH INSURANCE COSTS.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for coverage of the taxpayer, his spouse, and dependents.

"(b) LIMITATIONS.—

"(1) MAXIMUM CREDIT.—

"(A) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year.

"(B) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the lesser of—

"(i) the product of $1,000 multiplied by the number of individuals taken into account under subsection (a) who are covered under qualified health insurance as of the first day of such month, or

"(ii) $3,000.

"(2) EMPLOYER SUBSIDIZED COVERAGE.—Subsection (a) shall not apply to amounts paid for coverage of any individual for any month for which such individual participates in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer. The rule of the last sentence of section 162(l)(2)(B) shall apply for purposes of the preceding sentence.

"(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care if—

"(A) such insurance meets the requirements of section 223(c)(2)(A)(ii),

"(B) there is no exclusion from, or limitation on, coverage for any preexisting medical condition of any applicant who, on the date the application is made, has been continuously insured during the 1-year period ending on the date of the application under—

"(i) qualified health insurance (determined without regard to this subparagraph), or

"(ii) a program described in—

"(I) title XVIII or XIX of the Social Security Act,

"(II) chapter 55 of title 10, United States Code,

"(III) chapter 17 of title 38, United States Code,

"(IV) chapter 89 of title 5, United States Code, or

"(V) the Indian Health Care Improvement Act, and

"(C) in the case of each applicant who has not been continuously so insured during the 1-year period ending on the date the application is made, the exclusion from, or limitation on, coverage for any preexisting medical condition

does not extend beyond the period after such date equal to the lesser of—

"(i) the number of months immediately prior to such date during which the individual was not so insured since the illness or condition in question was first diagnosed, or

"(ii) 1 year.

"(2) EXCLUSION OF CERTAIN PLANS.—Such term does not include—

"(A) insurance if substantially all of its coverage is coverage described in section 223(c)(1)(B),

"(B) insurance under a program described in paragraph (1)(B)(ii).

"(3) TRANSITION RULE FOR 2005.—In the case of applications made during 2005, the requirements of subparagraphs (C) and (D) of paragraph (1) are met only if the insurance does not exclude from coverage, or limit coverage for, any preexisting medical condition of any applicant.

"(d) SPECIAL RULES.—

"(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be

taken into account in computing the amount allowable to the taxpayer as a credit under section 35 or as a deduction under section 162(l) or 213(a).

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

''(3) MARRIED COUPLES MUST FILE JOINT RETURN.—

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

''(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

''(4) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section to any individual unless such individual's coverage under qualified health insurance, and the amount paid for such

coverage, are verified in such manner as the Secretary may prescribe.

''(5) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

''(6) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2005, each dollar amount contained in subsection (b)(1)(B) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2004' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $10.''.

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

"SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS.

"(a) GENERAL RULE.—The Secretary shall establish a program for making payments on behalf of individuals to providers of qualified health insurance (as defined in section 36(c)) for such individuals.

"(b) LIMITATION ON ADVANCE PAYMENTS DURING ANY TAXABLE YEAR.—The Secretary may make payments under subsection (a) only to the extent that the total amount of such payments made on behalf of any individual during the taxable year does not exceed the amount allowable as a credit to such individual for such year under section 36 (determined without regard to subsection (d)(5) thereof).".

(c) CONFORMING AMENDMENTS.—

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

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item

relating to section 36 and inserting the following new items:

"Sec. 36. Health insurance costs.
"Sec. 37. Overpayments of tax.".

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

"Sec. 7527A. Advance payment of credit for health insurance costs.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2004.

SEC. 502. EXCLUSION FOR EMPLOYER PAYMENTS MADE TO COMPENSATE EMPLOYEES WHO ELECT NOT TO PARTICIPATE IN EMPLOYER-SUBSIDIZED HEALTH PLANS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139A the following new section:

"SEC. 139B. TREATMENT OF COMPENSATING PAYMENTS MADE FOR EMPLOYEES WHO ELECT NOT TO PARTICIPATE IN EMPLOYER-SUBSIDIZED HEALTH PLANS.

"(a) IN GENERAL.—Gross income of an eligible employee shall not include the amount of any compensating

coverage payment made by an employer of such employee for such employee's benefit.

''(b) ELIGIBLE EMPLOYEE.—For purposes of this section, the term 'eligible employee' means any employee who is eligible to participate in any subsidized health plan of an employer for any period and who elects not to participate in any subsidized health plan of such employer for such period.

''(c) COMPENSATING COVERAGE PAYMENT.—For purposes of this section, the term 'compensating coverage payment' means—

''(1) any payment made by the employer for qualified health insurance specified by the employee (for any period for which the employee is described in subsection (b)) which covers all of the individuals who, but for the election referred to in subsection (b), would be covered under the subsidized health plan of the employer, and

''(2) any payment made by the employer to any Archer MSA or health savings account of such employee or spouse for a period for which the employee is covered by qualified health insurance.

''(d) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' has the meaning given such term in section 36(c).

''(e) EMPLOYER PARTICIPATION.—

''(1) IN GENERAL.—This section shall apply to a compensating coverage payment made by an employer for an employee's benefit only if—

''(A) the employer, and all other employers which are members of any controlled group which includes such employer, agree to make such payments to all their eligible employees,

''(B) the amount of such payment is not less than the employer health plan contribution for such period with respect to the employee, and

''(C) the employer permits the election referred to in subsection (b) to be made by employees—

''(i) at the commencement of employment with the employer, and

''(ii) during open enrollment periods (not less frequently than annually) of at least 30 days.

''(2) EXCEPTION FOR CERTAIN EMPLOYEES.—Paragraph (1) shall not apply to—

''(A) any employee who is covered under a subsidized health plan of another employer of

such employee or of an employer of such employee's spouse,

"(B) any employee who normally works less than 25 hours per week,

"(C) any employee who normally works during not more than 6 months during any year,

"(D) any employee who has not attained age 21, and

"(E) except to the extent provided in regulations, any employee who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and the employer.

"(3) CONTROLLED GROUPS.—Rules similar to the rules of subclauses (II) and (III) of paragraph (4)(D)(iii) shall apply for purposes of paragraph (1)(A).

"(4) EMPLOYER HEALTH PLAN CONTRIBUTION.—For purposes of this section—

"(A) IN GENERAL.—The term 'employer health plan contribution' means the applicable premium for the employee reduced by the employee's share of such premium.

"(B) APPLICABLE PREMIUM.—Except as provided in subparagraph (D), the term 'applicable premium' means an amount which is not less than 98 percent of—

"(i) the applicable premium (as defined in section 4980B(f)(4)) for the employee, or

"(ii) if an election under subparagraph (D) is in effect with respect to an employee, the applicable premium determined under subparagraph (D).

"(C) EMPLOYEE'S SHARE.—The term 'employee's share' means, with respect to the applicable premium for any employee, the amount of the cost to the plan which is paid by the similarly situated beneficiaries who are taken into account in determining such premium for such employee.

"(D) AUTHORITY TO USE AGE, SEX, AND GEOGRAPHY IN DETERMINING CONTRIBUTION.—

"(i) IN GENERAL.—An employer may elect to determine the applicable premium for an employee on an actuarial basis taking into account age, sex, and geography of

the employee and similarly situated beneficiaries.

''(ii) DETERMINATION OF EMPLOYEE'S SHARE.—In the case of an employer who determines the applicable premium under clause (i), the employee's share of such premium shall be the same percentage of such premium as the employee's share of the applicable premium determined without regard to clause (i).

''(iii) CONSISTENCY REQUIRED.—

''(I) IN GENERAL.—Except as provided in subclause (III), an employer may determine the applicable premium under this subparagraph for any employee only if such employer, and all other employers which are members of any controlled group which includes such employer, elect to determine the applicable premium under this subparagraph for all their employees.

''(II) CONTROLLED GROUP.—All persons treated as a single employer under subsection (a) or (b) of section

52 or subsection (m) or (o) of section 414 shall be treated as members of a controlled group for purposes of subclause (I).

''(III) TREATMENT OF SEPARATE LINES OF BUSINESS.—If an employer is treated under section 414(r) as operating separate lines of business during any taxable year, subclause (I) shall not apply to employees employed in such separate lines of business.

''(f) SPECIAL RULE FOR ARCHER MSAS AND HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—Sections 220(b)(5) and 223(b)(4) shall not apply to an employer contribution which is excludable from gross income under subsection (a).

''(g) EXCLUSION APPLICABLE IN DETERMINING EMPLOYMENT TAX LIABILITY.—The exclusion under this section shall be treated for purposes of subtitle C in the same manner as the exclusion under section 106.''

(b) EMPLOYER HEALTH PLAN CONTRIBUTION TO BE REPORTED ON W–2.—Subsection (a) of section 6051 of such Code (relating to receipts to employees) is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting

a comma, and by inserting after paragraph (13) the following new paragraphs:

''(14) the amount of the employer health plan contribution (as defined in section 139(c)(3)), and

''(15) the amount of compensating coverage payment (as defined in section 139(c)(1)).''

(c) CLERICAL AMENDMENT.—The table of sections for such part III is amended by inserting after the item relating to section 139A the following new item:

''Sec. 139B. Treatment of compensating payments made for employees who elect not to participate in employer-subsidized health plans.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2005.

TITLE VI—PATIENT ACCESS TO INFORMATION

SEC. 601. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

"(i) types of items and services (including any special disease management program); and

"(ii) types of health care professionals providing such items and services.

"(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

"(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

"(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

"(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6

of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

"(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

"(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

"(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

"(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

''(2) the circumstances under which, and the extent to which, the participant's financial responsi-

bility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) ACCOUNTABILITY.—The information required under subsection (a) includes a description of the legal recourse options available for participants and beneficiaries under the plan including—

''(1) the preemption that applies under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) to certain actions arising out of the provision of health benefits;

''(2) the ability of a participant or beneficiary (or the estate of the participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; and

''(3) the extent to which coverage decisions made by the plan are subject to internal review or any external review and the proper time frames under which such reviews may be requested and conducted.

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

"(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

"(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

"(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review

organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her profes-

sional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

"(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

"(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in con-

nection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations;

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants);

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification; or

''(4) by any other reasonable means of timely informing plan participants.''.

SEC. 602. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by section 601 shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by section 601 before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by section 601, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

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