

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

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.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Patients’ Health Care Reform Act”.

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Purposes.

TITLE I—HEALTHMARTS

Sec. 101. Expansion of consumer choice through Healthmarts.

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

Sec. 201. Expansion of access and choice through individual membership asso-
ciations (IMAs).

**TITLE III—FEDERAL MATCHING FUNDING FOR STATE
INSURANCE EXPENDITURES**

Sec. 301. Federal matching funding for State insurance expenditures.

**TITLE IV—AFFORDABLE HEALTH COVERAGE FOR EMPLOYEES
OF SMALL BUSINESSES**

Sec. 401. Short title of title.
Sec. 402. Rules.
Sec. 403. Clarification of treatment of single employer arrangements.
Sec. 404. Clarification of treatment of certain collectively bargained arrange-
ments.
Sec. 405. Enforcement provisions.
Sec. 406. Cooperation between Federal and State authorities.
Sec. 407. Effective date and transitional and other rules.

**TITLE V—IMPROVEMENT TO ACCESS AND CHOICE OF HEALTH
CARE**

Sec. 501. Refundable and advanceable credit for health insurance costs.
Sec. 502. Exclusion for employer payments made to compensate employees who
elect not to participate in employer-subsidized health plans.

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.
Sec. 602. Effective date.

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

1 this Act rests is the power of Congress to regulate com-
2 merce with foreign nations and among the several States,
3 set forth in article I, section 8 of the United States Con-
4 stitution.

5 **SEC. 2. FINDINGS.**

6 (a) **NEED FOR STRUCTURAL REFORMS.**—Congress
7 finds that the majority of Americans are receiving health
8 care of a quality unmatched elsewhere in the world but
9 that the method by which health care currently is financed
10 and delivered is inflationary and does not distribute qual-
11 ity care to all Americans. Congress further finds that the
12 major structural reforms must be implemented in order
13 to institute a competitive system based on individual
14 choice, under which each American is permitted individual
15 choice to select the method of health care delivery which
16 he believes is most appropriate for himself and his family,
17 with appropriate assistance from the United States Gov-
18 ernment. Such a system would introduce internal incen-
19 tives for the cost-effective delivery of quality health care
20 to the American people.

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

24 (1) **EMPLOYER OWNERSHIP OF HEALTH BENE-**
25 **FITS.**—The biggest problem with health care today

1 is that the tax code has encouraged employers, not
2 individuals, to become the purchaser of health insur-
3 ance. Employers have a tax incentive to offer health
4 care benefits to their employees, which means that
5 employers are truly the owner of the plan, not indi-
6 viduals. Therefore employees, who are the consumers
7 of health care services are unconcerned with and not
8 involved with issues of cost and overutilize health
9 care services in the belief that such services are
10 “free”.

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

17 (3) EXCESSIVE GOVERNMENT REGULATION.—
18 Continually increasing and complex Government reg-
19 ulation of the economic aspects of the health care
20 delivery system has proven ineffective in restraining
21 costs and is itself expensive and counterproductive in
22 fulfilling its purposes and detrimental to the care of
23 patients.

24 (4) THIRD-PARTY PAYMENT SYSTEMS.—Pay-
25 ment by third-party payers (including commercial in-

1 surance companies and various levels of government)
2 for the preponderance of the health care delivered
3 each year insulates patients, as well as physicians,
4 hospitals, and other deliverers of health care, from
5 the need to consider the cost of treatment in addi-
6 tion to the medical benefit expected from it.

7 (5) REASONABLE COST REIMBURSEMENT.—Re-
8 imbursement of hospitals and other health care insti-
9 tutions by third-party payers on the basis of reason-
10 able costs of operation provides these institutions in-
11 sufficient incentives to introduce more efficient
12 methods of delivering care and at the same time di-
13 minishes the extent to which these institutions and
14 their patients are affected by the consequences of in-
15 efficiency and overexpansion.

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

22 (7) LACK OF COMPETITION.—The present sys-
23 tem of financing and regulation prevents health care
24 deliverers from competing with each other on the
25 basis of efficiency and price as well as quality.

1 **SEC. 3. PURPOSES.**

2 The purposes of Act are—

3 (1) to make it possible for individuals, employ-
4 ees, and the self-employed to purchase and own their
5 own health insurance without suffering any negative
6 tax consequences;

7 (2) to enable individuals to make their own in-
8 formed choice of the method by which their health
9 care is provided, the persons who deliver it, and the
10 price they wish to pay for it;

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

13 (4) to render patients and deliverers sensitive to
14 the cost of health care, giving them both the incen-
15 tive and the ability to restrain undesired increases in
16 health care costs;

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

19 (6) to foster the development of numerous, var-
20 ied, and innovative systems of providing health care
21 which will compete against each other in terms of
22 price, service, and quality, and thus allow the Amer-
23 ican people to benefit from competitive forces which
24 will reward efficient and effective deliverers and
25 eliminate those which provide unsatisfactory quality
26 of care or are inefficient;

1 (7) to replace governmental regulation of the
 2 economic aspects of health care delivery with indi-
 3 vidual choice, private initiative, and marketplace in-
 4 centives and disciplines;

5 (8) to encourage the development of systems of
 6 delivering health care which are capable of supplying
 7 a broad range of health care services in a com-
 8 prehensive and systematic manner, and

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

13 **TITLE I—HEALTHMARTS**

14 **SEC. 101. EXPANSION OF CONSUMER CHOICE THROUGH** 15 **HEALTHMARTS.**

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

18 **“TITLE XXIX—HEALTHMARTS**

19 **“SEC. 2901. DEFINITION OF HEALTHMART.**

20 “(a) IN GENERAL.—For purposes of this title, the
 21 term ‘HealthMart’ means a legal entity that meets the fol-
 22 lowing requirements:

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

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

3 “(A) Employers.

4 “(B) Employees.

5 “(C) Individuals (other than those de-
6 scribed in subparagraph (B)) who are eligible to
7 participate in the HealthMart.

8 “(D) Health care providers, which may be
9 physicians, other health care professionals,
10 health care facilities, or any combination there-
11 of.

12 “(E) Entities, such as insurance compa-
13 nies, health maintenance organizations, and li-
14 censed provider-sponsored organizations, that
15 underwrite or administer health benefits cov-
16 erage.

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

19 “(A) DIFFERENT GROUPS.—The
20 HealthMart, in conjunction with those health
21 insurance issuers that offer health benefits cov-
22 erage through the HealthMart, makes available
23 health benefits coverage in the manner de-
24 scribed in subsection (b) to all employers, eligi-
25 ble 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

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

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

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

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

17 “(3) GEOGRAPHIC AREAS.—

18 “(A) SPECIFICATION OF GEOGRAPHIC
19 AREAS.—The HealthMart shall specify the geo-
20 graphic area (or areas) in which it makes avail-
21 able health benefits coverage offered by health
22 insurance issuers to employers, or individuals,
23 as the case may be. Any such area shall encom-
24 pass at least one entire county or equivalent
25 area.

1 “(B) MULTISTATE AREAS.—In the case of
2 a HealthMart that serves more than one State,
3 such geographic areas may be areas that in-
4 clude portions of two or more contiguous
5 States.

6 “(C) MULTIPLE HEALTHMARTS PER-
7 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-
8 ing in this title shall be construed as preventing
9 the establishment and operation of more than
10 one HealthMart in a geographic area or as lim-
11 iting the number of HealthMarts that may op-
12 erate in any area.

13 “(4) PROVISION OF ADMINISTRATIVE SERVICES
14 TO PURCHASERS.—

15 “(A) IN GENERAL.—The HealthMart pro-
16 vides administrative services for purchasers.
17 Such services may include accounting, billing,
18 enrollment information, and employee coverage
19 status reports.

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

24 “(5) DISSEMINATION OF INFORMATION.—The
25 HealthMart collects and disseminates (or arranges

1 for the collection and dissemination of) consumer-
2 oriented information on the scope, cost, and enrollee
3 satisfaction of all coverage options offered through
4 the HealthMart to its members and eligible individ-
5 uals. Such information shall be defined by the
6 HealthMart and shall be in a manner appropriate to
7 the type of coverage offered. To the extent prac-
8 ticable, such information shall include information
9 on provider performance, locations and hours of op-
10 eration of providers, outcomes, and similar matters.
11 Nothing in this section shall be construed as pre-
12 venting the dissemination of such information or
13 other information by the HealthMart or by health
14 insurance issuers through electronic or other means.

15 “(6) FILING INFORMATION.—The
16 HealthMart—

17 “(A) files with the applicable Federal au-
18 thority information that demonstrates the
19 HealthMart’s compliance with the applicable re-
20 quirements of this title; or

21 “(B) in accordance with rules established
22 under section 2903(a), files with a State such
23 information as the State may require to dem-
24 onstrate such compliance.

1 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
2 MENTS.—

3 “(1) COMPLIANCE WITH CONSUMER PROTEC-
4 TION REQUIREMENTS.—Any health benefits coverage
5 offered through a HealthMart shall—

6 “(A) be underwritten by a health insurance
7 issuer that—

8 “(i) is licensed (or otherwise regu-
9 lated) under State law,

10 “(ii) meets all applicable State stand-
11 ards relating to consumer protection, sub-
12 ject to section 2902(b), and

13 “(iii) offers the coverage under a con-
14 tract with the HealthMart;

15 “(B) subject to paragraph (2), be approved
16 or otherwise permitted to be offered under
17 State law; and

18 “(C) provide full portability of creditable
19 coverage for individuals who remain members of
20 the same HealthMart notwithstanding that they
21 change the employer through which they are
22 members in accordance with the provisions of
23 the parts 6 and 7 of subtitle B of title I of the
24 Employee Retirement Income Security Act of
25 1974 and titles XXII and XXVII of this Act,

1 so long as both employers are purchasers in the
2 HealthMart, and notwithstanding that they ter-
3 minate such employment, if the HealthMart
4 permits enrollment directly by eligible individ-
5 uals.

6 “(2) ALTERNATIVE PROCESS FOR APPROVAL OF
7 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMI-
8 NATION OR DELAY.—

9 “(A) IN GENERAL.—The requirement of
10 paragraph (1)(B) shall not apply to a policy or
11 product of health benefits coverage offered in a
12 State if the health insurance issuer seeking to
13 offer such policy or product files an application
14 to waive such requirement with the applicable
15 Federal authority, and the authority deter-
16 mines, based on the application and other evi-
17 dence presented to the authority, that—

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

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

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

1 product of health benefits coverage are as fol-
2 lows:

3 “(i) FAILURE TO ACT ON POLICY,
4 PRODUCT, OR RATE APPLICATION ON A
5 TIMELY BASIS.—The State has failed to
6 complete action on the policy or product
7 (or rates for the policy or product) within
8 90 days of the date of the State’s receipt
9 of a substantially complete application. No
10 period before the date of the enactment of
11 this section shall be included in deter-
12 mining such 90-day period.

13 “(ii) DENIAL OF APPLICATION BASED
14 ON DISCRIMINATORY TREATMENT.—The
15 State has denied such an application
16 and—

17 “(I) the standards or review
18 process imposed by the State as a
19 condition of approval of the policy or
20 product imposes either any material
21 requirements, procedures, or stand-
22 ards to such policy or product that
23 are not generally applicable to other
24 policies and products offered or any

1 requirements that are preempted
2 under section 2902; or

3 “(II) the State requires the
4 issuer, as a condition of approval of
5 the policy or product, to offer any pol-
6 icy or product other than such policy
7 or product.

8 “(C) ENFORCEMENT.—In the case of a
9 waiver granted under subparagraph (A) to an
10 issuer with respect to a State, the Secretary
11 may enter into an agreement with the State
12 under which the State agrees to provide for
13 monitoring and enforcement activities with re-
14 spect to compliance of such an issuer and its
15 health insurance coverage with the applicable
16 State standards described in subparagraph
17 (A)(ii). Such monitoring and enforcement shall
18 be conducted by the State in the same manner
19 as the State enforces such standards with re-
20 spect to other health insurance issuers and
21 plans, without discrimination based on the type
22 of issuer to which the standards apply. Such an
23 agreement shall specify or establish mechanisms
24 by which compliance activities are undertaken,
25 while not lengthening the time required to re-

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

3 “(3) EXAMPLES OF TYPES OF COVERAGE.—The
4 benefits coverage made available through a
5 HealthMart may include, but is not limited to, any
6 of the following if it meets the other applicable re-
7 quirements of this title:

8 “(A) Coverage through a health mainte-
9 nance organization.

10 “(B) Coverage in connection with a pre-
11 ferred provider organization.

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

14 “(D) Indemnity coverage through an insur-
15 ance company.

16 “(E) Coverage offered in connection with a
17 contribution into a medical savings account or
18 flexible spending account.

19 “(F) Coverage that includes a point-of-
20 service option.

21 “(G) Any combination of such types of
22 coverage.

23 “(4) WELLNESS BONUSES FOR HEALTH PRO-
24 MOTION.—Nothing in this title shall be construed as
25 precluding a health insurance issuer offering health

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

10 “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE
11 ISSUERS.—

12 “(1) PURCHASERS.—

13 “(A) IN GENERAL.—Subject to the provi-
14 sions of this title, a HealthMart shall permit
15 any employer or any individual described in
16 subsection (a)(1)(C) to contract with the
17 HealthMart for the purchase of health benefits
18 coverage for its employees and dependents of
19 those employees or for the individual (and the
20 individual’s dependents), respectively, and may
21 not vary conditions of eligibility (including pre-
22 mium rates and membership fees) of an em-
23 ployer or individual to be a purchaser.

24 “(B) ROLE OF ASSOCIATIONS, BROKERS,
25 AND LICENSED HEALTH INSURANCE AGENTS.—

1 Nothing in this section shall be construed as
2 preventing an association, broker, licensed
3 health insurance agent, or other entity from as-
4 sisting or representing a HealthMart or employ-
5 ers or individuals from entering into appro-
6 priate arrangements to carry out this title.

7 “(C) PERIOD OF CONTRACT.—The
8 HealthMart may not require a contract under
9 subparagraph (A) between a HealthMart and a
10 purchaser to be effective for a period of longer
11 than 24 months. The previous sentence shall
12 not be construed as preventing such a contract
13 from being extended for additional 24-month
14 periods or preventing the purchaser from volun-
15 tarily electing a contract period of longer than
16 24 months.

17 “(D) EXCLUSIVE NATURE OF CON-
18 TRACT.—

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

1 “(ii) EXCEPTION IF NO COVERAGE OF-
2 FERED IN AREA OF RESIDENCES.—Clause
3 (i) shall not apply to an eligible individual
4 who resides in an area for which no cov-
5 erage is offered by any health insurance
6 issuer through the HealthMart.

7 “(iii) NOTHING PRECLUDING INDI-
8 VIDUAL EMPLOYEE OPT-OUT.—Nothing in
9 this subparagraph shall be construed as re-
10 quiring an eligible employee of a large or
11 small employer that is a purchaser to ob-
12 tain health benefits coverage through the
13 HealthMart.

14 “(2) MEMBERS.—

15 “(A) IN GENERAL.—

16 “(i) EMPLOYMENT BASED MEMBER-
17 SHIP.—Under rules established to carry
18 out this title, with respect to an employer
19 that has a purchaser contract with a
20 HealthMart, individuals who are employees
21 of the employer may enroll for health bene-
22 fits coverage (including coverage for de-
23 pendents of such enrolling employees) of-
24 fered by a health insurance issuer through
25 the HealthMart.

1 “(ii) INDIVIDUALS.—Under rules es-
2 tablished to carry out this title, with re-
3 spect to an individual who has a purchaser
4 contract with a HealthMart for himself or
5 herself, the individual may enroll for health
6 benefits coverage (including coverage for
7 dependents of such individual) offered by a
8 health insurance issuer through the
9 HealthMart.

10 “(B) NONDISCRIMINATION IN ENROLL-
11 MENT.—A HealthMart may not deny enroll-
12 ment as a member to an individual who is an
13 employee or individual (or dependent of such an
14 employee or individual) eligible to be so enrolled
15 based on health status-related factors, except as
16 may be permitted consistent with section
17 2742(b).

18 “(C) ANNUAL OPEN ENROLLMENT PE-
19 RIOD.—In the case of members enrolled in
20 health benefits coverage offered by a health in-
21 surance issuer through a HealthMart, subject
22 to subparagraph (D), the HealthMart shall pro-
23 vide for an annual open enrollment period of 30
24 days during which such members may change

1 the coverage option in which the members are
2 enrolled.

3 “(D) RULES OF ELIGIBILITY.—Nothing in
4 this paragraph shall preclude a HealthMart
5 from establishing rules of employee or indi-
6 vidual eligibility for enrollment and reenroll-
7 ment of members during the annual open en-
8 rollment period under subparagraph (C). Such
9 rules shall be applied consistently to all pur-
10 chasers and members within the HealthMart
11 and shall not be based in any manner on health
12 status-related factors and may not conflict with
13 sections 2701 and 2702 of this Act.

14 “(3) HEALTH INSURANCE ISSUERS.—

15 “(A) PREMIUM COLLECTION.—The con-
16 tract between a HealthMart and a health insur-
17 ance issuer shall provide, with respect to a
18 member enrolled with health benefits coverage
19 offered by the issuer through the HealthMart,
20 for the payment of the premiums collected by
21 the HealthMart (or the issuer) for such cov-
22 erage (less a pre-determined administrative
23 charge negotiated by the HealthMart and the
24 issuer) to the issuer.

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

7 “(C) AVAILABILITY OF COVERAGE OP-
8 TIONS.—

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

14 “(ii) REQUIREMENT OF NON-NET-
15 WORK OPTION.—At least one of the health
16 insurance coverage options made available
17 under clause (i) shall be a non-network
18 coverage option under which enrollees may
19 obtain benefits for health care items and
20 services that are not provided under a con-
21 tract between the provider of the service
22 and the issuer involved.

23 “(d) PREVENTION OF CONFLICTS OF INTEREST.—

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

1 serve as an employee or paid consultant to the
2 HealthMart, but may receive reasonable reimburse-
3 ment for travel expenses for purposes of attending
4 meetings of the board or committees thereof.

5 “(2) FOR BOARDS OF DIRECTORS OR EMPLOY-
6 EES.—An individual is not eligible to serve in a paid
7 or unpaid capacity on the board of directors of a
8 HealthMart or as an employee of the HealthMart, if
9 the individual is employed by, represents in any ca-
10 pacity, owns, or controls any ownership interest in
11 an organization from whom the HealthMart receives
12 contributions, grants, or other funds not connected
13 with a contract for coverage through the
14 HealthMart.

15 “(3) EMPLOYMENT AND EMPLOYEE REP-
16 RESENTATIVES.—

17 “(A) IN GENERAL.—An individual who is
18 serving on a board of directors of a HealthMart
19 as a representative described in subparagraph
20 (A) or (B) of section 2901(a)(1) shall not be
21 employed by or affiliated with a health insur-
22 ance issuer or be licensed as or employed by or
23 affiliated with a health care provider.

24 “(B) CONSTRUCTION.—For purposes of
25 subparagraph (A), the term ‘affiliated’ does not

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

4 “(e) CONSTRUCTION.—

5 “(1) NETWORK OF AFFILIATED
6 HEALTHMARTS.—Nothing in this section shall be
7 construed as preventing one or more HealthMarts
8 serving different areas (whether or not contiguous)
9 from providing for some or all of the following
10 (through a single administrative organization or oth-
11 erwise):

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

15 “(B) Providing for crediting of deductibles
16 and other cost-sharing for individuals who are
17 provided health benefits coverage through the
18 HealthMarts (or affiliated HealthMarts)
19 after—

20 “(i) a change of employers through
21 which the coverage is provided, or

22 “(ii) a change in place of employment
23 to an area not served by the previous
24 HealthMart.

1 “(2) PERMITTING HEALTHMARTS TO ADJUST
 2 DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-
 3 ATIVE RISK OF ENROLLEES.—Nothing in this sec-
 4 tion shall be construed as precluding a HealthMart
 5 from providing for adjustments in amounts distrib-
 6 uted among the health insurance issuers offering
 7 health benefits coverage through the HealthMart
 8 based on factors such as the relative health care risk
 9 of members enrolled under the coverage offered by
 10 the different issuers.

11 **“SEC. 2902. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
 12 **MENTS.**

13 “(a) AUTHORITY OF STATES.—Nothing in this sec-
 14 tion shall be construed as preempting State laws relating
 15 to the following:

16 “(1) The regulation of underwriters of health
 17 coverage, including licensure and solvency require-
 18 ments.

19 “(2) The application of premium taxes and re-
 20 quired payments for guaranty funds or for contribu-
 21 tions to high-risk pools.

22 “(3) The application of fair marketing require-
 23 ments and other consumer protections (other than
 24 those specifically relating to an item described in
 25 subsection (b)).

1 “(4) The application of requirements relating to
2 the adjustment of rates for health insurance cov-
3 erage.

4 “(b) TREATMENT OF BENEFIT AND GROUPING RE-
5 QUIREMENTS.—State laws insofar as they relate to any
6 of the following are superseded and shall not apply to
7 health benefits coverage made available through a
8 HealthMart:

9 “(1) Benefit requirements for health benefits
10 coverage offered through a HealthMart, including
11 (but not limited to) requirements relating to cov-
12 erage of specific providers, specific services or condi-
13 tions, or the amount, duration, or scope of benefits,
14 but not including requirements to the extent re-
15 quired to implement title XXVII or other Federal
16 law and to the extent the requirement prohibits an
17 exclusion of a specific disease from such coverage.

18 “(2) Requirements (commonly referred to as
19 fictitious group laws) relating to grouping and simi-
20 lar requirements for such coverage to the extent
21 such requirements impede the establishment and op-
22 eration of HealthMarts pursuant to this title.

23 “(3) Any other requirements (including limita-
24 tions on compensation arrangements) that, directly
25 or indirectly, preclude (or have the effect of pre-

1 cluding) the offering of such coverage through a
2 HealthMart, if the HealthMart meets the require-
3 ments of this title.

4 Any State law or regulation relating to the composition
5 or organization of a HealthMart is preempted to the ex-
6 tent the law or regulation is inconsistent with the provi-
7 sions of this title.

8 “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-
9 CLOSURE REQUIREMENTS.—The board of directors of a
10 HealthMart is deemed to be a plan administrator of an
11 employee welfare benefit plan which is a group health plan
12 for purposes of applying parts 1 and 4 of subtitle B of
13 title I of the Employee Retirement Income Security Act
14 of 1974 and those provisions of part 5 of such subtitle
15 which are applicable to enforcement of such parts 1 and
16 4, and the HealthMart shall be treated as such a plan
17 and the enrollees enrolled on the basis of employment shall
18 be treated as participants and beneficiaries for purposes
19 of applying such provisions pursuant to this subsection.

20 “(d) APPLICATION OF ERISA RENEWABILITY PRO-
21 TECTION.—A HealthMart is deemed to be group health
22 plan that is a multiple employer welfare arrangement for
23 purposes of applying section 703 of the Employee Retire-
24 ment Income Security Act of 1974.

1 “(e) APPLICATION OF RULES FOR NETWORK PLANS
2 AND FINANCIAL CAPACITY.—The provisions of sub-
3 sections (c) and (d) of section 2711 apply to health bene-
4 fits coverage offered by a health insurance issuer through
5 a HealthMart.

6 “(f) CONSTRUCTION RELATING TO OFFERING RE-
7 QUIREMENT.—Nothing in section 2711(a) of this Act or
8 703 of the Employee Retirement Income Security Act of
9 1974 shall be construed as permitting the offering outside
10 the HealthMart of health benefits coverage that is only
11 made available through a HealthMart under this section
12 because of the application of subsection (b).

13 “(g) APPLICATION TO GUARANTEED RENEWABILITY
14 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN
15 ISSUER.—For purposes of applying section 2712 in the
16 case of health insurance coverage offered by a health in-
17 surance issuer through a HealthMart, if the contract be-
18 tween the HealthMart and the issuer is terminated and
19 the HealthMart continues to make available any health in-
20 surance coverage after the date of such termination, the
21 following rules apply:

22 “(1) RENEWABILITY.—The HealthMart shall
23 fulfill the obligation under such section of the issuer
24 renewing and continuing in force coverage by offer-
25 ing purchasers (and members and their dependents)

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

6 “(2) APPLICATION OF ASSOCIATION RULES.—

7 The HealthMart shall be considered an association
8 for purposes of applying section 2712(e).

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

16 **“SEC. 2903. ADMINISTRATION.**

17 “(a) IN GENERAL.—The applicable Federal authority
18 shall administer this title and is authorized to issue such
19 regulations as may be required to carry out this title. Such
20 regulations shall be subject to Congressional review under
21 the provisions of chapter 8 of title 5, United States Code.
22 The applicable Federal authority shall incorporate the
23 process of ‘deemed file and use’ with respect to the infor-
24 mation filed under section 2901(a)(6)(A) and shall deter-
25 mine whether information filed by a HealthMart dem-

1 onstrates compliance with the applicable requirements of
 2 this title. Such authority shall exercise its authority under
 3 this title in a manner that fosters and promotes the devel-
 4 opment of HealthMarts in order to improve access to
 5 health care coverage and services.

6 “(b) PERIODIC REPORTS.—The applicable Federal
 7 authority shall submit to Congress a report every 30
 8 months, during the 10-year period beginning on the effec-
 9 tive date of the rules promulgated by the applicable Fed-
 10 eral authority to carry out this title, on the effectiveness
 11 of this title in promoting coverage of uninsured individ-
 12 uals. Such authority may provide for the production of
 13 such reports through one or more contracts with appro-
 14 priate private entities.

15 **“SEC. 2904. DEFINITIONS.**

16 “For purposes of this title:

17 “(1) APPLICABLE FEDERAL AUTHORITY.—The
 18 term ‘applicable Federal authority’ means the Sec-
 19 retary of Health and Human Services .

20 “(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—
 21 The term ‘eligible’ means, with respect to an em-
 22 ployee or other individual and a HealthMart, an em-
 23 ployee or individual who is eligible under section
 24 2901(c)(2) to enroll or be enrolled in health benefits
 25 coverage offered through the HealthMart.

1 “(3) EMPLOYER; EMPLOYEE; DEPENDENT.—
2 Except as the applicable Federal authority may oth-
3 erwise provide, the terms ‘employer’, ‘employee’, and
4 ‘dependent’, as applied to health insurance coverage
5 offered by a health insurance issuer licensed (or oth-
6 erwise regulated) in a State, shall have the meanings
7 applied to such terms with respect to such coverage
8 under the laws of the State relating to such coverage
9 and such an issuer. The term ‘dependent’ may in-
10 clude the spouse and children of the individual in-
11 volved.

12 “(4) HEALTH BENEFITS COVERAGE.—The term
13 ‘health benefits coverage’ has the meaning given the
14 term group health insurance coverage in section
15 2791(b)(4).

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

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

22 “(7) HEALTHMART.—The term ‘HealthMart’ is
23 defined in section 2901(a).

24 “(8) MEMBER.—The term ‘member’ means,
25 with respect to a HealthMart, an individual enrolled

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

3 “(9) PURCHASER.—The term ‘purchaser’
4 means, with respect to a HealthMart, an employer
5 or individual that has contracted under section
6 2901(c)(1)(A) with the HealthMart for the purchase
7 of health benefits coverage.”.

8 **TITLE II—HEALTH CARE ACCESS**
9 **AND CHOICE THROUGH INDIVIDUAL**
10 **MEMBERSHIP ASSOCIATIONS (IMAS)**
11

12 **SEC. 201. EXPANSION OF ACCESS AND CHOICE THROUGH**
13 **INDIVIDUAL MEMBERSHIP ASSOCIATIONS**
14 **(IMAS).**

15 The Public Health Service Act, as amended by sec-
16 tion 101, is further amended by adding at the end the
17 following new title:

18 **“TITLE XXX—INDIVIDUAL**
19 **MEMBERSHIP ASSOCIATIONS**

20 **“SEC. 3001. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-**
21 **SOCIATION (IMA).**

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

1 “(1) ORGANIZATION.—The IMA is an organiza-
2 tion operated under the direction of an association
3 (as defined in section 3004(1)).

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

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

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

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

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

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

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

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

18 “(4) PROVISION OF ADMINISTRATIVE SERVICES
19 TO PURCHASERS.—

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

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

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

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

7 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
8 MENTS.—

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

12 “(A) be underwritten by a health insurance
13 issuer that—

14 “(i) is licensed (or otherwise regu-
15 lated) under State law,

16 “(ii) meets all applicable State stand-
17 ards relating to consumer protection, sub-
18 ject to section 3002(b), and

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

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

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

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

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

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

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

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

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

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

18 “(3) WELLNESS BONUSES FOR HEALTH PRO-
19 MOTION.—Nothing in this title shall be construed as
20 precluding a health insurance issuer offering health
21 benefits coverage through an IMA from establishing
22 premium discounts or rebates for members or from
23 modifying otherwise applicable copayments or
24 deductibles in return for adherence to programs of
25 health promotion and disease prevention so long as

1 such programs are agreed to in advance by the IMA
2 and comply with all other provisions of this title and
3 do not discriminate among similarly situated mem-
4 bers.

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

6 “(1) MEMBERS.—

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

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

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

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

3 **“SEC. 3002. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
4 **MENTS.**

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

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

17 “(2) Any other requirements (including limita-
18 tions on compensation arrangements) that, directly
19 or indirectly, preclude (or have the effect of pre-
20 cluding) the offering of such coverage through an
21 IMA, if the IMA meets the requirements of this
22 title.

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

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

3 **“SEC. 3003. ADMINISTRATION.**

4 “(a) IN GENERAL.—The Secretary shall administer
5 this title and is authorized to issue such regulations as
6 may be required to carry out this title. Such regulations
7 shall be subject to Congressional review under the provi-
8 sions of chapter 8 of title 5, United States Code. The Sec-
9 retary shall incorporate the process of ‘deemed file and
10 use’ with respect to the information filed under section
11 3001(a)(5)(A) and shall determine whether information
12 filed by an IMA demonstrates compliance with the applica-
13 ble requirements of this title. The Secretary shall exercise
14 authority under this title in a manner that fosters and
15 promotes the development of IMAs in order to improve
16 access to health care coverage and services.

17 “(b) PERIODIC REPORTS.—The Secretary shall sub-
18 mit to Congress a report every 30 months, during the 10-
19 year period beginning on the effective date of the rules
20 promulgated by the Secretary to carry out this title, on
21 the effectiveness of this title in promoting coverage of un-
22 insured individuals. The Secretary may provide for the
23 production of such reports through one or more contracts
24 with appropriate private entities.

1 **“SEC. 3004. DEFINITIONS.**

2 “For purposes of this title:

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

6 “(A) has been actively in existence for at
7 least 5 years;

8 “(B) has been formed and maintained in
9 good faith for purposes other than obtaining in-
10 surance;

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

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

20 “(2) DEPENDENT.—The term ‘dependent’, as
21 applied to health insurance coverage offered by a
22 health insurance issuer licensed (or otherwise regu-
23 lated) in a State, shall have the meaning applied to
24 such term with respect to such coverage under the
25 laws of the State relating to such coverage and such

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

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

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

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

13 “(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIA-
14 TION.—The terms ‘IMA’ and ‘individual membership
15 association’ are defined in section 3001(a).

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

1 **TITLE III—FEDERAL MATCHING**
2 **FUNDING FOR STATE INSUR-**
3 **ANCE EXPENDITURES**

4 **SEC. 301. FEDERAL MATCHING FUNDING FOR STATE IN-**
5 **SURANCE EXPENDITURES.**

6 (a) IN GENERAL.—Subject to the succeeding provi-
7 sions of this section, each State shall receive from the Sec-
8 retary of Health and Human Services an amount equal
9 to 50 percent of the funds expended by the State in pro-
10 viding for the use, in connection with providing health ben-
11 efits coverage, of a high-risk pool, a reinsurance pool, or
12 other risk-adjustment mechanism used for the purpose of
13 subsidizing the purchase of private health insurance.

14 (b) FUNDING LIMITATION.—A State shall not receive
15 under this section for a fiscal year more than a total of
16 50 cents multiplied by the average number of residents
17 (as estimated by the Secretary) in the State in the fiscal
18 year.

19 (c) ADMINISTRATION.—The Secretary of Health and
20 Human Services shall provide for the administration of
21 this section and may establish such terms and conditions,
22 including the requirement of an application, as may be ap-
23 propriate to carry out this section.

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

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

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

8 (f) REINSURANCE POOL OR OTHER RISK-ADJUST-
 9 MENT MECHANISM DEFINED.—For purposes of this sec-
 10 tion, the term “reinsurance pool or other risk-adjustment
 11 mechanism” means any State-based risk spreading mecha-
 12 nism to subsidize the purchase of private health insurance
 13 for the high-risk population.

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

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

21 (2) individuals who are provided health cov-
 22 erage by a high-risk pool.

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

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

3 **TITLE IV—AFFORDABLE HEALTH**
4 **COVERAGE FOR EMPLOYEES**
5 **OF SMALL BUSINESSES**

6 **SEC. 401. SHORT TITLE OF TITLE.**

7 This title may be cited as the “Small Business Access
8 and Choice for Entrepreneurs Act of 2005”.

9 **SEC. 402. RULES.**

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

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

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

16 “(a) IN GENERAL.—For purposes of this part, the
17 term ‘association health plan’ means a group health
18 plan—

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

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

1 pants and beneficiaries, unless, for any plan year,
2 such coverage remains unavailable to the plan de-
3 spite good faith efforts exercised by the plan to se-
4 cure such coverage.

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

7 “(1) is organized and maintained in good faith,
8 with a constitution and bylaws specifically stating its
9 purpose and providing for periodic meetings on at
10 least an annual basis, as a bona fide trade associa-
11 tion, a bona fide industry association (including a
12 rural electric cooperative association or a rural tele-
13 phone cooperative association), a bona fide profes-
14 sional association, or a bona fide chamber of com-
15 merce (or similar bona fide business association, in-
16 cluding a corporation or similar organization that
17 operates on a cooperative basis (within the meaning
18 of section 1381 of the Internal Revenue Code of
19 1986)), for substantial purposes other than that of
20 obtaining or providing medical care;

21 “(2) is established as a permanent entity which
22 receives the active support of its members and col-
23 lects from its members on a periodic basis dues or
24 payments necessary to maintain eligibility for mem-
25 bership in the sponsor; and

1 “(3) does not condition membership, such dues
2 or payments, or coverage under the plan on the
3 basis of health status-related factors with respect to
4 the employees of its members (or affiliated mem-
5 bers), or the dependents of such employees, and does
6 not condition such dues or payments on the basis of
7 group health plan participation.

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

12 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
13 **PLANS.**

14 “(a) IN GENERAL.—The applicable authority shall
15 prescribe by regulation, through negotiated rulemaking, a
16 procedure under which, subject to subsection (b), the ap-
17 plicable authority shall certify association health plans
18 which apply for certification as meeting the requirements
19 of this part.

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

1 requirements of this part only if the applicable authority is
 2 satisfied that—

3 “(1) such certification—

4 “(A) is administratively feasible;

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

7 “(C) is protective of the rights and benefits
 8 of the individuals covered under the plan; and

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

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

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

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

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

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

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

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

21 “(3) a plan whose eligible participating employ-
22 ers represent one or more trades or businesses, or
23 one or more industries, which have been indicated as
24 having average or above-average health insurance
25 risk or health claims experience by reason of State

1 rate filings, denials of coverage, proposed premium
2 rate levels, and other means demonstrated by such
3 plan in accordance with regulations which the Sec-
4 retary shall prescribe through negotiated rule-
5 making, including (but not limited to) the following:
6 agriculture; automobile dealerships; barbering and
7 cosmetology; child care; construction; dance, theat-
8 rical, and orchestra productions; disinfecting and
9 pest control; eating and drinking establishments;
10 fishing; hospitals; labor organizations; logging; man-
11 ufacturing (metals); mining; medical and dental
12 practices; medical laboratories; sanitary services;
13 transportation (local and freight); and warehousing.

14 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
15 **BOARDS OF TRUSTEES.**

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

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

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

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

12 “(3) RULES GOVERNING RELATIONSHIP TO
13 PARTICIPATING EMPLOYERS AND TO CONTRAC-
14 TORS.—

15 “(A) IN GENERAL.—Except as provided in
16 subparagraphs (B) and (C), the members of the
17 board of trustees are individuals selected from
18 individuals who are the owners, officers, direc-
19 tors, or employees of the participating employ-
20 ers or who are partners in the participating em-
21 ployers and actively participate in the business.

22 “(B) LIMITATION.—

23 “(i) GENERAL RULE.—Except as pro-
24 vided in clauses (ii) and (iii), no such
25 member is an owner, officer, director, or

1 employee of, or partner in, a contract ad-
2 ministrator or other service provider to the
3 plan.

4 “(ii) LIMITED EXCEPTION FOR PRO-
5 VIDERS OF SERVICES SOLELY ON BEHALF
6 OF THE SPONSOR.—Officers or employees
7 of a sponsor which is a service provider
8 (other than a contract administrator) to
9 the plan may be members of the board if
10 they constitute not more than 25 percent
11 of the membership of the board and they
12 do not provide services to the plan other
13 than on behalf of the sponsor.

14 “(iii) TREATMENT OF PROVIDERS OF
15 MEDICAL CARE.—In the case of a sponsor
16 which is an association whose membership
17 consists primarily of providers of medical
18 care, clause (i) shall not apply in the case
19 of any service provider described in sub-
20 paragraph (A) who is a provider of medical
21 care under the plan.

22 “(C) CERTAIN PLANS EXCLUDED.—Sub-
23 paragraph (A) shall not apply to an association
24 health plan which is in existence on the date of

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

3 “(D) SOLE AUTHORITY.—The board has
4 sole authority under the plan to approve appli-
5 cations for participation in the plan and to con-
6 tract with a service provider to administer the
7 day-to-day affairs of the plan.

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

12 “(1) the requirements of subsection (a) and sec-
13 tion 801(a)(1) shall be deemed met if such require-
14 ments would otherwise be met if the franchiser were
15 deemed to be the sponsor referred to in section
16 801(b), such network were deemed to be an associa-
17 tion described in section 801(b), and each franchisee
18 were deemed to be a member (of the association and
19 the sponsor) referred to in section 801(b); and

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

22 The Secretary may by regulation, through negotiated rule-
23 making, define for purposes of this subsection the terms
24 ‘franchiser’, ‘franchise network’, and ‘franchisee’.

25 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

5 “(B) the joint board of trustees shall be
6 deemed a board of trustees with respect to
7 which the requirements of subsection (b) are
8 met; and

9 “(C) the requirements of section 804 shall
10 be deemed met.

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

13 “(A) the plan is a multiemployer plan; or

14 “(B) the plan is in existence on April 1,
15 1997, and would be described in section
16 3(40)(A)(i) but solely for the failure to meet
17 the requirements of section 3(40)(C)(ii).

18 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
19 **MENTS.**

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

24 “(1) each participating employer must be—

25 “(A) a member of the sponsor;

1 “(B) the sponsor; or

2 “(C) an affiliated member of the sponsor
3 with respect to which the requirements of sub-
4 section (b) are met;

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

14 “(2) all individuals commencing coverage under
15 the plan after certification under this part must
16 be—

17 “(A) active or retired owners (including
18 self-employed individuals), officers, directors, or
19 employees of, or partners in, participating em-
20 ployers; or

21 “(B) the beneficiaries of individuals de-
22 scribed in subparagraph (A).

23 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
24 PLOYEES.—In the case of an association health plan in
25 existence on the date of the enactment of the Small Busi-

1 ness Access and Choice for Entrepreneurs Act of 2005,
2 an affiliated member of the sponsor of the plan may be
3 offered coverage under the plan as a participating em-
4 ployer only if—

5 “(1) the affiliated member was an affiliated
6 member on the date of certification under this part;
7 or

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

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

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

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

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

16 “(3) the applicable requirements of sections
 17 701, 702, and 703 are met with respect to the plan.

18 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
 19 **DOCUMENTS, CONTRIBUTION RATES, AND**
 20 **BENEFIT OPTIONS.**

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

24 “(1) CONTENTS OF GOVERNING INSTRU-
 25 MENTS.—The instruments governing the plan in-

1 clude a written instrument, meeting the require-
2 ments of an instrument required under section
3 402(a)(1), which—

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

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

12 “(C) incorporates the requirements of sec-
13 tion 806.

14 “(2) CONTRIBUTION RATES MUST BE NON-
15 DISCRIMINATORY.—

16 “(A) The contribution rates for any par-
17 ticipating small employer do not vary on the
18 basis of the claims experience of such employer
19 and do not vary on the basis of the type of
20 business or industry in which such employer is
21 engaged.

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

1 connection with an association health plan,
2 from—

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

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

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

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

23 “(4) MARKETING REQUIREMENTS.—

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

1 offered under the plan, State-licensed insurance
2 agents shall be used to distribute to small em-
3 ployers coverage which does not consist of
4 health insurance coverage in a manner com-
5 parable to the manner in which such agents are
6 used to distribute health insurance coverage.

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

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

21 “(b) HEALTH BENEFIT OPTIONS UNDER AN ASSO-
22 CIATION HEALTH PLAN.—

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

1 ited to, any of the following if it meets the other ap-
2 plicable requirements of this title:

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

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

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

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

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

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

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

18 “(2) HEALTH INSURANCE COVERAGE OP-
19 TIONS.—

20 “(A) IN GENERAL.—An association health
21 plan shall include a minimum of 4 health insur-
22 ance coverage options. At least 1 option shall be
23 a non network option. At least 2 options shall
24 meet all applicable State benefit mandates.

1 “(B) MODEL BENEFITS PACKAGE.—The
2 Secretary in consultation with the National As-
3 sociation of Insurance Commissioners shall de-
4 velop a model benefits package for health insur-
5 ance coverage not later than one year after the
6 date of the enactment of the Consensus Health
7 Care Access and Choice Act of 2003.

8 “(C) EXCEPTION TO GENERAL RULE.—An
9 association health plan may offer 2 options that
10 meet the requirements of the model benefits
11 package in lieu of the State benefit mandate of-
12 ferings required under subparagraph (A).

13 “(3) PERMITTING ASSOCIATION HEALTH PLANS
14 TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO RE-
15 FLECT RELATIVE RISK OF ENROLLEES.—Nothing in
16 this section shall be construed as precluding an asso-
17 ciation health plan from providing for adjustments
18 in amounts distributed among the health insurance
19 issuers offering health benefits coverage through the
20 association health plan based on factors such as the
21 relative health care risk of members enrolled under
22 the coverage offered by the different issuers.

23 “(4) CONSTRUCTION.—Except as provided in
24 subparagraph (2), nothing in this part or any provi-
25 sion of State law (as defined in section 514(c)(1))

1 shall be construed to preclude an association health
2 plan, or a health insurance issuer offering health in-
3 surance coverage in connection with an association
4 health plan, from exercising its sole discretion in se-
5 lecting the specific items and services consisting of
6 medical care to be included as benefits under such
7 plan or coverage, except (subject to section 514) in
8 the case of any law to the extent that it (1) prohibits
9 an exclusion of a specific disease from such cov-
10 erage, or (2) is not preempted under section
11 731(a)(1) with respect to matters governed by sec-
12 tion 711 or 712.

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

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

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

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

24 “(A) establishes and maintains reserves
25 with respect to such additional benefit options,

1 in amounts recommended by the qualified actu-
2 ary, consisting of—

3 “(i) a reserve sufficient for unearned
4 contributions;

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

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

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

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

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

1 annual claims. The applicable authority
2 may by regulation, through negotiated
3 rulemaking, provide for upward adjust-
4 ments in the amount of such percentage in
5 specified circumstances in which the plan
6 specifically provides for and maintains re-
7 serves in excess of the amounts required
8 under subparagraph (A).

9 “(ii) The plan shall secure specific ex-
10 cess /stop loss insurance for the plan with
11 an attachment point which is at least equal
12 to an amount recommended by the plan’s
13 qualified actuary (but not more than
14 \$175,000). The applicable authority may
15 by regulation, through negotiated rule-
16 making, provide for adjustments in the
17 amount of such insurance in specified cir-
18 cumstances in which the plan specifically
19 provides for and maintains reserves in ex-
20 cess of the amounts required under sub-
21 paragraph (A).

22 “(iii) The plan shall secure indem-
23 nification insurance for any claims which
24 the plan is unable to satisfy by reason of
25 a plan termination.

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

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

12 “(1) \$500,000, or

13 “(2) such greater amount (but not greater than
14 \$2,000,000) as may be set forth in regulations pre-
15 scribed by the applicable authority through nego-
16 tiated rulemaking, based on the level of aggregate
17 and specific excess /stop loss insurance provided with
18 respect to such plan.

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

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

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

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

1 of participating employers, security, or other financial ar-
2 rangement.

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

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

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

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

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

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

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

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

8 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

1 “(g) EXCESS /STOP LOSS INSURANCE.—For pur-
2 poses of this section—

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

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

14 “(B) which is guaranteed renewable; and

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

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

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

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

5 “(B) which is guaranteed renewable; and

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

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

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

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

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

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

7 “(j) SOLVENCY STANDARDS WORKING GROUP.—

8 “(1) IN GENERAL.—Within 90 days after the
9 date of the enactment of the Small Business Access
10 and Choice for Entrepreneurs Act of 2005, the ap-
11 plicable authority shall establish a Solvency Stand-
12 ards Working Group. In prescribing the initial regu-
13 lations under this section, the applicable authority
14 shall take into account the recommendations of such
15 Working Group.

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

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

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

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

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

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

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

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

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

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

1 be prescribed by the applicable authority through nego-
2 tiated rulemaking, at least the following information:

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

5 “(A) the sponsor; and

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

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

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

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

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

1 plan and contract administrators and other service
2 providers.

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

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

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

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

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

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

23 “(E) OTHER INFORMATION.—Any other
24 information as may be determined by the appli-
25 cable authority, by regulation through nego-

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

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

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

24 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
25 SOCIATION HEALTH PLANS.—An association health plan

1 certified under this part which provides benefit options in
2 addition to health insurance coverage for such plan year
3 shall meet the requirements of section 103 by filing an
4 annual report under such section which shall include infor-
5 mation described in subsection (b)(6) with respect to the
6 plan year and, notwithstanding section 104(a)(1)(A), shall
7 be filed with the applicable authority not later than 90
8 days after the close of the plan year (or on such later date
9 as may be prescribed by the applicable authority). The ap-
10 plicable authority may require by regulation through nego-
11 tiated rulemaking such interim reports as it considers ap-
12 propriate.

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

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

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

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

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

4 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.**
5

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

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

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

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

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

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

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

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

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

1 court shall appoint such Secretary trustee if the court de-
2 termines that the trusteeship is necessary to protect the
3 interests of the participants and beneficiaries or providers
4 of medical care or to avoid any unreasonable deterioration
5 of the financial condition of the plan. The trusteeship of
6 such Secretary shall continue until the conditions de-
7 scribed in the first sentence of this subsection are rem-
8 edied or the plan is terminated.

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

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

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

18 “(3) to invest any assets of the plan which the
19 Secretary holds in accordance with the provisions of
20 the plan, regulations prescribed by the Secretary
21 through negotiated rulemaking, and applicable provi-
22 sions of law;

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

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

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

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

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

14 “(8) to terminate the plan (or provide for its
15 termination accordance with section 809(b)) and liq-
16 uidate the plan assets, to restore the plan to the re-
17 sponsibility of the sponsor, or to continue the trust-
18 eeship;

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

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

1 pants and beneficiaries and providers of medical
2 care.

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

6 “(1) the sponsor and plan administrator;

7 “(2) each participant;

8 “(3) each participating employer; and

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

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

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

1 “(f) JURISDICTION OF COURT.—

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

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

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

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

15 “(a) IN GENERAL.—Notwithstanding section 514, a
16 State may impose by law a contribution tax on an associa-
17 tion health plan described in section 806(a)(2), if the plan
18 commenced operations in such State after the date of the
19 enactment of the Small Business Access and Choice for
20 Entrepreneurs Act of 2005.

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

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

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

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

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

1 nance organizations in such State in connection with
2 such plan.

3 **“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

4 “(a) ELECTION FOR CHURCH PLANS.—Notwith-
5 standing section 4(b)(2), if a church, a convention or asso-
6 ciation of churches, or an organization described in section
7 3(33)(C)(i) maintains a church plan which is a group
8 health plan (as defined in section 733(a)(1)), and such
9 church, convention, association, or organization makes an
10 election with respect to such plan under this subsection
11 (in such form and manner as the Secretary may by regula-
12 tion prescribe), then the provisions of this section shall
13 apply to such plan, with respect to benefits provided under
14 such plan consisting of medical care, as if section 4(b)(2)
15 did not contain an exclusion for church plans. Nothing in
16 this subsection shall be construed to render any other sec-
17 tion of this title applicable to church plans, except to the
18 extent that such other section is incorporated by reference
19 in this section.

20 “(b) EFFECT OF ELECTION.—

21 “(1) PREEMPTION OF STATE INSURANCE LAWS
22 REGULATING COVERED CHURCH PLANS.—Subject to
23 paragraphs (2) and (3), this section shall supersede
24 any and all State laws which regulate insurance in-
25 sofar as they may now or hereafter regulate church

1 plans to which this section applies or trusts estab-
2 lished under such church plans.

3 “(2) GENERAL STATE INSURANCE REGULATION
4 UNAFFECTED.—

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

10 “(B) CHURCH PLANS NOT TO BE DEEMED
11 INSURANCE COMPANIES OR INSURERS.—Neither
12 a church plan to which this section applies, nor
13 any trust established under such a church plan,
14 shall be deemed to be an insurance company or
15 other insurer or to be engaged in the business
16 of insurance for purposes of any State law pur-
17 porting to regulate insurance companies or in-
18 surance contracts.

19 “(3) PREEMPTION OF CERTAIN STATE LAWS
20 RELATING TO PREMIUM RATE REGULATION AND
21 BENEFIT MANDATES.—The provisions of subsections
22 (a)(2)(B) and (b) of section 805 shall apply with re-
23 spect to a church plan to which this section applies
24 in the same manner and to the same extent as such

1 provisions apply with respect to association health
2 plans.

3 “(4) DEFINITIONS.—For purposes of this sub-
4 section—

5 “(A) STATE LAW.—The term ‘State law’
6 includes all laws, decisions, rules, regulations,
7 or other State action having the effect of law,
8 of any State. A law of the United States appli-
9 cable only to the District of Columbia shall be
10 treated as a State law rather than a law of the
11 United States.

12 “(B) STATE.—The term ‘State’ includes a
13 State, any political subdivision thereof, or any
14 agency or instrumentality of either, which pur-
15 ports to regulate, directly or indirectly, the
16 terms and conditions of church plans covered by
17 this section.

18 “(c) REQUIREMENTS FOR COVERED CHURCH
19 PLANS.—

20 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-
21 POSE.—A fiduciary shall discharge his duties with
22 respect to a church plan to which this section ap-
23 plies—

24 “(A) for the exclusive purpose of:

1 “(i) providing benefits to participants
2 and their beneficiaries; and

3 “(ii) defraying reasonable expenses of
4 administering the plan;

5 “(B) with the care, skill, prudence and dili-
6 gence under the circumstances then prevailing
7 that a prudent man acting in a like capacity
8 and familiar with such matters would use in the
9 conduct of an enterprise of a like character and
10 with like aims; and

11 “(C) in accordance with the documents
12 and instruments governing the plan.

13 The requirements of this paragraph shall not be
14 treated as not satisfied solely because the plan as-
15 sets are commingled with other church assets, to the
16 extent that such plan assets are separately ac-
17 counted for.

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

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

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

3 “(B) afford a reasonable opportunity to
4 any participant whose claim for benefits has
5 been denied for a full and fair review by the ap-
6 propriate fiduciary of the decision denying the
7 claim; and

8 “(C) provide a written statement to each
9 participant describing the procedures estab-
10 lished pursuant to this paragraph.

11 “(3) ANNUAL STATEMENTS.—In accordance
12 with regulations of the Secretary, every church plan
13 to which this section applies shall file with the Sec-
14 retary an annual statement—

15 “(A) stating the names and addresses of
16 the plan and of the church, convention, or asso-
17 ciation maintaining the plan (and its principal
18 place of business);

19 “(B) certifying that it is a church plan to
20 which this section applies and that it complies
21 with the requirements of paragraphs (1) and
22 (2);

23 “(C) identifying the States in which par-
24 ticipants and beneficiaries under the plan are or

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

3 “(D) containing a copy of a statement of
4 actuarial opinion signed by a qualified actuary
5 that the plan maintains capital, reserves, insur-
6 ance, other financial arrangements, or any com-
7 bination thereof adequate to enable the plan to
8 fully meet all of its financial obligations on a
9 timely basis.

10 “(4) DISCLOSURE.—At the time that the an-
11 nual statement is filed by a church plan with the
12 Secretary pursuant to paragraph (3), a copy of such
13 statement shall be made available by the Secretary
14 to the State insurance commissioner (or similar offi-
15 cial) of any State. The name of each church plan
16 and sponsoring organization filing an annual state-
17 ment in compliance with paragraph (3) shall be pub-
18 lished annually in the Federal Register.

19 “(d) ENFORCEMENT.—The Secretary may enforce
20 the provisions of this section in a manner consistent with
21 section 502, to the extent applicable with respect to ac-
22 tions under section 502(a)(5), and with section 3(33)(D),
23 except that, other than for the purpose of seeking a tem-
24 porary restraining order, a civil action may be brought
25 with respect to the plan’s failure to meet any requirement

1 of this section only if the plan fails to correct its failure
 2 within the correction period described in section 3(33)(D).
 3 The other provisions of part 5 (except sections 501(a),
 4 503, 512, 514, and 515) shall apply with respect to the
 5 enforcement and administration of this section.

6 “(e) DEFINITIONS AND OTHER RULES.—For pur-
 7 poses of this section—

8 “(1) IN GENERAL.—Except as otherwise pro-
 9 vided in this section, any term used in this section
 10 which is defined in any provision of this title shall
 11 have the definition provided such term by such pro-
 12 vision.

13 “(2) SEMINARY STUDENTS.—Seminary students
 14 who are enrolled in an institution of higher learning
 15 described in section 3(33)(C)(iv) and who are treat-
 16 ed as participants under the terms of a church plan
 17 to which this section applies shall be deemed to be
 18 employees as defined in section 3(6) if the number
 19 of such students constitutes an insignificant portion
 20 of the total number of individuals who are treated
 21 as participants under the terms of the plan.

22 **“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

24 “(1) GROUP HEALTH PLAN.—The term ‘group
 25 health plan’ has the meaning provided in section

1 733(a)(1) (after applying subsection (b) of this sec-
2 tion).

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

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

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

11 “(5) APPLICABLE AUTHORITY.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraph (B), the term ‘applicable author-
14 ity’ means, in connection with an association
15 health plan—

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

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

22 “(B) EXCEPTIONS.—

23 “(i) JOINT AUTHORITIES.—Where
24 such term appears in section 808(3), sec-
25 tion 807(e) (in the first instance), section

1 809(a) (in the second instance), section
2 809(a) (in the fourth instance), and sec-
3 tion 809(b)(1), such term means, in con-
4 nection with an association health plan, the
5 Secretary and the State referred to in sub-
6 paragraph (A)(i) (if any) in connection
7 with such plan.

8 “(ii) REGULATORY AUTHORITIES.—
9 Where such term appears in section 802(a)
10 (in the first instance), section 802(d), sec-
11 tion 802(e), section 803(d), section
12 805(a)(5), section 806(a)(2), section
13 806(b), section 806(c), section 806(d),
14 paragraphs (1)(A) and (2)(A) of section
15 806(g), section 806(h), section 806(i), sec-
16 tion 806(j), section 807(a) (in the second
17 instance), section 807(b), section 807(d),
18 section 807(e) (in the second instance),
19 section 808 (in the matter after paragraph
20 (3)), and section 809(a) (in the third in-
21 stance), such term means, in connection
22 with an association health plan, the Sec-
23 retary.

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

4 “(7) INDIVIDUAL MARKET.—

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

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

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

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

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

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

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

21 “(10) QUALIFIED ACTUARY.—The term ‘quali-
22 fied actuary’ means an individual who is a member
23 of the American Academy of Actuaries or meets
24 such reasonable standards and qualifications as the

1 Secretary may provide by regulation through nego-
2 tiated rulemaking.

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

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

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

12 “(C) in the case of an association health
13 plan in existence on the date of the enactment
14 of the Small Business Access and Choice for
15 Entrepreneurs Act of 2005, a person eligible to
16 be a member of the sponsor or one of its mem-
17 ber associations.

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

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

5 “(b) RULES OF CONSTRUCTION.—

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

13 “(A) in the case of a partnership, the term
14 ‘employer’ (as defined in section (3)(5)) in-
15 cludes the partnership in relation to the part-
16 ners, and the term ‘employee’ (as defined in
17 section (3)(6)) includes any partner in relation
18 to the partnership; and

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

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

1 lished or is maintained for the purpose of providing
2 medical care (through the purchase of insurance or
3 otherwise) for employees (or their dependents) cov-
4 ered thereunder and which demonstrates to the Sec-
5 retary that all requirements for certification under
6 this part would be met with respect to such plan,
7 fund, or program if such plan, fund, or program
8 were a group health plan, such plan, fund, or pro-
9 gram shall be treated for purposes of this title as an
10 employee welfare benefit plan on and after the date
11 of such demonstration.”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 icipating employer’, and ‘health insurance issuer’ have
 2 the meanings provided such terms in section 811, respec-
 3 tively.”.

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

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

8 (B) in clause (ii), by inserting “and which
 9 does not provide medical care (within the mean-
 10 ing of section 733(a)(2)),” after “arrange-
 11 ment,” and by striking “title.” and inserting
 12 “title, and”; and

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

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

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

23 (A) by striking “Nothing” and inserting
 24 “(1) Except as provided in paragraph (2), noth-
 25 ing”; and

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

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of the Small Busi-
5 ness Access and Choice for Entrepreneurs Act of 2005
6 shall be construed to alter, amend, modify, invalidate, im-
7 pair, or supersede any provision of this title, except by
8 specific cross-reference to the affected section.”.

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

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

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

13 **SEC. 403. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 14 **PLOYER ARRANGEMENTS.**

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

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

6 (2) in clause (iii)—

7 (A) by striking “common control shall not
8 be based on an interest of less than 25 percent”
9 and inserting “an interest of greater than 25
10 percent may not be required as the minimum
11 interest necessary for common control”; and

12 (B) by striking “similar to” and inserting
13 “consistent and coextensive with”;

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

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

18 “(iv) in determining, after the application of
19 clause (i), whether benefits are provided to employ-
20 ees of two or more employers, the arrangement shall
21 be treated as having only one participating employer
22 if, after the application of clause (i), the number of
23 individuals who are employees and former employees
24 of any one participating employer and who are cov-
25 ered under the arrangement is greater than 75 per-

1 cent of the aggregate number of all individuals who
 2 are employees or former employees of participating
 3 employers and who are covered under the arrange-
 4 ment;”.

5 **SEC. 404. CLARIFICATION OF TREATMENT OF CERTAIN**
 6 **COLLECTIVELY BARGAINED ARRANGE-**
 7 **MENTS.**

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

11 “(i)(I) under or pursuant to one or more collec-
 12 tive bargaining agreements which are reached pursu-
 13 ant to collective bargaining described in section 8(d)
 14 of the National Labor Relations Act (29 U.S.C.
 15 158(d)) or paragraph Fourth of section 2 of the
 16 Railway Labor Act (45 U.S.C. 152, paragraph
 17 Fourth) or which are reached pursuant to labor-
 18 management negotiations under similar provisions of
 19 State public employee relations laws, and (II) in ac-
 20 cordance with subparagraphs (C), (D), and (E);”.

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

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

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

3 “(i) The plan or other arrangement, and the
4 employee organization or any other entity sponsoring
5 the plan or other arrangement, do not—

6 “(I) utilize the services of any licensed in-
7 surance agent or broker for soliciting or enroll-
8 ing employers or individuals as participating
9 employers or covered individuals under the plan
10 or other arrangement; or

11 “(II) pay any type of compensation to a
12 person, other than a full time employee of the
13 employee organization (or a member of the or-
14 ganization to the extent provided in regulations
15 prescribed by the Secretary through negotiated
16 rulemaking), that is related either to the volume
17 or number of employers or individuals solicited
18 or enrolled as participating employers or cov-
19 ered individuals under the plan or other ar-
20 rangement, or to the dollar amount or size of
21 the contributions made by participating employ-
22 ers or covered individuals to the plan or other
23 arrangement;

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

1 of preparation of documents necessary for compliance with
2 the reporting and disclosure requirements of part 1 or ad-
3 ministrative, investment, or consulting services unrelated
4 to solicitation or enrollment of covered individuals.

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

8 “(I) employed within a bargaining unit
9 covered by any of the collective bargaining
10 agreements with a participating employer (nor
11 covered on the basis of an individual’s employ-
12 ment in such a bargaining unit); nor

13 “(II) present employees (or former employ-
14 ees who were covered while employed) of the
15 sponsoring employee organization, of an em-
16 ployer who is or was a party to any of the col-
17 lective bargaining agreements, or of the plan or
18 other arrangement or a related plan or arrange-
19 ment (nor covered on the basis of such present
20 or former employment);

21 does not exceed 15 percent of the total number of
22 individuals who are covered under the plan or ar-
23 rangement and who are present or former employees
24 who are or were covered under the plan or arrange-
25 ment pursuant to a collective bargaining agreement

1 with a participating employer. The requirements of
2 the preceding provisions of this clause shall be treat-
3 ed as satisfied if, as of the end of the preceding plan
4 year, such covered individuals are comprised solely
5 of individuals who were covered individuals under
6 the plan or other arrangement as of the date of the
7 enactment of the Small Business Access and Choice
8 for Entrepreneurs Act of 2003 and, as of the end of
9 the preceding plan year, the number of such covered
10 individuals does not exceed 25 percent of the total
11 number of present and former employees enrolled
12 under the plan or other arrangement.

13 “(iii) The employee organization or other entity
14 sponsoring the plan or other arrangement certifies
15 to the Secretary each year, in a form and manner
16 which shall be prescribed by the Secretary through
17 negotiated rulemaking that the plan or other ar-
18 rangement meets the requirements of clauses (i) and
19 (ii).

20 “(D) For purposes of subparagraph (A)(i)(II), a plan
21 or arrangement shall be treated as established or main-
22 tained in accordance with this subparagraph only if—

23 “(i) all of the benefits provided under the plan
24 or arrangement consist of health insurance coverage;
25 or

1 “(ii)(I) the plan or arrangement is a multiem-
2 ployer plan; and

3 “(II) the requirements of clause (B) of the pro-
4 viso to clause (5) of section 302(c) of the Labor
5 Management Relations Act, 1947 (29 U.S.C.
6 186(c)) are met with respect to such plan or other
7 arrangement.

8 “(E) For purposes of subparagraph (A)(i)(II), a plan
9 or arrangement shall be treated as established or main-
10 tained in accordance with this subparagraph only if—

11 “(i) the plan or arrangement is in effect as of
12 the date of the enactment of the Small Business Ac-
13 cess and Choice for Entrepreneurs Act of 2005; or

14 “(ii) the employee organization or other entity
15 sponsoring the plan or arrangement—

16 “(I) has been in existence for at least 3
17 years; or

18 “(II) demonstrates to the satisfaction of
19 the Secretary that the requirements of subpara-
20 graphs (C) and (D) are met with respect to the
21 plan or other arrangement.”.

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

1 vidual who is a covered individual described in paragraph
 2 (40)(C)(ii).”.

3 **SEC. 405. ENFORCEMENT PROVISIONS.**

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

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

9 (2) by adding at the end the following new sub-
 10 section:

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

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

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

1 reached pursuant to labor-management negotiations
2 under similar provisions of State public employee re-
3 lations laws; or

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

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

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

13 “(n)(1) Subject to paragraph (2), upon application
14 by the Secretary showing the operation, promotion, or
15 marketing of an association health plan (or similar ar-
16 rangement providing benefits consisting of medical care
17 (as defined in section 733(a)(2))) that—

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

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

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

9 “(A) all benefits under it referred to in para-
10 graph (1) consist of health insurance coverage; and

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

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

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

22 (1) by inserting “(a) In General.—” after “Sec.
23 503.”; and

24 (2) by adding at the end the following new sub-
25 section:

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

7 **SEC. 406. COOPERATION BETWEEN FEDERAL AND STATE**
 8 **AUTHORITIES.**

9 Section 506 of the Employee Retirement Income Se-
 10 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
 11 at the end the following new subsection:

12 “(d) RESPONSIBILITY OF STATES WITH RESPECT TO
 13 ASSOCIATION HEALTH PLANS.—

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

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

20 “(B) the Secretary’s authority to certify
 21 association health plans under part 8 in accord-
 22 ance with regulations of the Secretary applica-
 23 ble to certification under part 8; or

1 “(C) any combination of the Secretary’s
2 authority authorized to be delegated under sub-
3 paragraphs (A) and (B).

4 “(2) DELEGATIONS.—Any department, agency,
5 or instrumentality of a State to which authority is
6 delegated pursuant to an agreement entered into
7 under this paragraph may, if authorized under State
8 law and to the extent consistent with such agree-
9 ment, exercise the powers of the Secretary under
10 this title which relate to such authority.

11 “(3) RECOGNITION OF PRIMARY DOMICILE
12 STATE.—In entering into any agreement with a
13 State under subparagraph (A), the Secretary shall
14 ensure that, as a result of such agreement and all
15 other agreements entered into under subparagraph
16 (A), only one State will be recognized, with respect
17 to any particular association health plan, as the
18 State to which all authority has been delegated pur-
19 suant to such agreements in connection with such
20 plan. In carrying out this paragraph, the Secretary
21 shall take into account the places of residence of the
22 participants and beneficiaries under the plan and the
23 State in which the trust is maintained.”.

1 **SEC. 407. EFFECTIVE DATE AND TRANSITIONAL AND**
2 **OTHER RULES.**

3 (a) **EFFECTIVE DATE.**—The amendments made by
4 sections 101, 104, and 105 shall take effect on January
5 1, 2007. The amendments made by sections 102 and 103
6 shall take effect on the date of the enactment of this Act.
7 The Secretary of Labor shall first issue all regulations
8 necessary to carry out the amendments made by this sub-
9 title before January 1, 2007. Such regulations shall be
10 issued through negotiated rulemaking.

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

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

21 (1) **IN GENERAL.**—In any case in which, as of
22 the date of the enactment of this Act, an arrange-
23 ment is maintained in a State for the purpose of
24 providing benefits consisting of medical care for the
25 employees and beneficiaries of its participating em-
26 ployers, at least 200 participating employers make

1 contributions to such arrangement, such arrange-
2 ment has been in existence for at least 10 years, and
3 such arrangement is licensed under the laws of one
4 or more States to provide such benefits to its par-
5 ticipating employers, upon the filing with the appli-
6 cable authority (as defined in section 813(a)(5) of
7 the Employee Retirement Income Security Act of
8 1974 (as amended by this Act)) by the arrangement
9 of an application for certification of the arrangement
10 under part 8 of subtitle B of title I of such Act—

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

14 (B) the requirements of sections 801(a)(1)
15 and 803(a)(1) of the Employee Retirement In-
16 come Security Act of 1974 shall be deemed met
17 with respect to such arrangement;

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

22 (i) is elected by the participating em-
23 ployers, with each employer having one
24 vote; and

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

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

7 (E) the arrangement may be certified by
8 any applicable authority with respect to its op-
9 erations in any State only if it operates in such
10 State on the date of certification.

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

16 (2) DEFINITIONS.—For purposes of this sub-
17 section, the terms “group health plan”, “medical
18 care”, and “participating employer” shall have the
19 meanings provided in section 813 of the Employee
20 Retirement Income Security Act of 1974, except
21 that the reference in paragraph (7) of such section
22 to an “association health plan” shall be deemed a
23 reference to an arrangement referred to in this sub-
24 section.

1 **TITLE V—IMPROVEMENT TO AC-**
2 **CESS AND CHOICE OF**
3 **HEALTH CARE**

4 **SEC. 501. REFUNDABLE AND ADVANCEABLE CREDIT FOR**
5 **HEALTH INSURANCE COSTS.**

6 (a) IN GENERAL.—Subpart C of part IV of sub-
7 chapter A of chapter 1 of the Internal Revenue Code of
8 1986 (relating to refundable credits) is amended by redes-
9 ignating section 36 as section 37 and by inserting after
10 section 35 the following new section:

11 **“SEC. 36. HEALTH INSURANCE COSTS.**

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

17 “(b) LIMITATIONS.—

18 “(1) MAXIMUM CREDIT.—

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

1 “(B) MONTHLY LIMITATION.—The month-
2 ly limitation for any month is the amount equal
3 to $\frac{1}{12}$ of the lesser of—

4 “(i) the product of \$1,000 multiplied
5 by the number of individuals taken into ac-
6 count under subsection (a) who are covered
7 under qualified health insurance as of the
8 first day of such month, or

9 “(ii) \$3,000.

10 “(2) EMPLOYER SUBSIDIZED COVERAGE.—Sub-
11 section (a) shall not apply to amounts paid for cov-
12 erage of any individual for any month for which
13 such individual participates in any subsidized health
14 plan maintained by any employer of the taxpayer or
15 of the spouse of the taxpayer. The rule of the last
16 sentence of section 162(l)(2)(B) shall apply for pur-
17 poses of the preceding sentence.

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

20 “(1) IN GENERAL.—The term ‘qualified health
21 insurance’ means insurance which constitutes med-
22 ical care if—

23 “(A) such insurance meets the require-
24 ments of section 223(c)(2)(A)(ii),

1 “(B) there is no exclusion from, or limita-
2 tion on, coverage for any preexisting medical
3 condition of any applicant who, on the date the
4 application is made, has been continuously in-
5 sured during the 1-year period ending on the
6 date of the application under—

7 “(i) qualified health insurance (deter-
8 mined without regard to this subpara-
9 graph), or

10 “(ii) a program described in—

11 “(I) title XVIII or XIX of the
12 Social Security Act,

13 “(II) chapter 55 of title 10,
14 United States Code,

15 “(III) chapter 17 of title 38,
16 United States Code,

17 “(IV) chapter 89 of title 5,
18 United States Code, or

19 “(V) the Indian Health Care Im-
20 provement Act, and

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

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

3 “(i) the number of months imme-
4 diately prior to such date during which the
5 individual was not so insured since the ill-
6 ness or condition in question was first di-
7 agnosed, or

8 “(ii) 1 year.

9 “(2) EXCLUSION OF CERTAIN PLANS.—Such
10 term does not include—

11 “(A) insurance if substantially all of its
12 coverage is coverage described in section
13 223(c)(1)(B),

14 “(B) insurance under a program described
15 in paragraph (1)(B)(ii).

16 “(3) TRANSITION RULE FOR 2005.—In the case
17 of applications made during 2005, the requirements
18 of subparagraphs (C) and (D) of paragraph (1) are
19 met only if the insurance does not exclude from cov-
20 erage, or limit coverage for, any preexisting medical
21 condition of any applicant.

22 “(d) SPECIAL RULES.—

23 “(1) COORDINATION WITH MEDICAL DEDUC-
24 TION, ETC.—Any amount paid by a taxpayer for in-
25 surance to which subsection (a) applies shall not be

1 taken into account in computing the amount allow-
2 able to the taxpayer as a credit under section 35 or
3 as a deduction under section 162(l) or 213(a).

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

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

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

17 “(B) MARITAL STATUS; CERTAIN MARRIED
18 INDIVIDUALS LIVING APART.—Rules similar to
19 the rules of paragraphs (3) and (4) of section
20 21(e) shall apply for purposes of this para-
21 graph.

22 “(4) VERIFICATION OF COVERAGE, ETC.—No
23 credit shall be allowed under this section to any indi-
24 vidual unless such individual’s coverage under quali-
25 fied health insurance, and the amount paid for such

1 coverage, are verified in such manner as the Sec-
 2 retary may prescribe.

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

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

16 “(A) such dollar amount, multiplied by

17 “(B) the cost-of-living adjustment deter-
 18 mined under section 1(f)(3) for the calendar
 19 year in which the taxable year begins by sub-
 20 stituting ‘calendar year 2004’ for ‘calendar year
 21 1992’ in subparagraph (B) thereof.

22 Any increase determined under the preceding sen-
 23 tence shall be rounded to the nearest multiple of
 24 \$10.”.

1 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 of
 2 such Code (relating to miscellaneous provisions) is amend-
 3 ed by inserting after section 7527 the following new sec-
 4 tion:

5 **“SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
 6 **INSURANCE COSTS.**

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

11 “(b) LIMITATION ON ADVANCE PAYMENTS DURING
 12 ANY TAXABLE YEAR.—The Secretary may make pay-
 13 ments under subsection (a) only to the extent that the
 14 total amount of such payments made on behalf of any indi-
 15 vidual during the taxable year does not exceed the amount
 16 allowable as a credit to such individual for such year under
 17 section 36 (determined without regard to subsection (d)(5)
 18 thereof).”.

19 (c) CONFORMING AMENDMENTS.—

20 (1) Paragraph (2) of section 1324(b) of title
 21 31, United States Code, is amended by inserting “or
 22 36” after “section 35”.

23 (2) The table of sections for subpart C of part
 24 IV of subchapter A of chapter 1 of the Internal Rev-
 25 enue Code of 1986 is amended by striking the item

1 relating to section 36 and inserting the following
 2 new items:

“Sec. 36. Health insurance costs.
 “Sec. 37. Overpayments of tax.”.

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

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

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

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

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

17 **“SEC. 139B. TREATMENT OF COMPENSATING PAYMENTS**
 18 **MADE FOR EMPLOYEES WHO ELECT NOT TO**
 19 **PARTICIPATE IN EMPLOYER-SUBSIDIZED**
 20 **HEALTH PLANS.**

21 “(a) IN GENERAL.—Gross income of an eligible em-
 22 ployee shall not include the amount of any compensating

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

3 “(b) ELIGIBLE EMPLOYEE.—For purposes of this
4 section, the term ‘eligible employee’ means any employee
5 who is eligible to participate in any subsidized health plan
6 of an employer for any period and who elects not to par-
7 ticipate in any subsidized health plan of such employer
8 for such period.

9 “(c) COMPENSATING COVERAGE PAYMENT.—For
10 purposes of this section, the term ‘compensating coverage
11 payment’ means—

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

19 “(2) any payment made by the employer to any
20 Archer MSA or health savings account of such em-
21 ployee or spouse for a period for which the employee
22 is covered by qualified health insurance.

23 “(d) QUALIFIED HEALTH INSURANCE.—For pur-
24 poses of this section, the term ‘qualified health insurance’
25 has the meaning given such term in section 36(c).

1 “(e) EMPLOYER PARTICIPATION.—

2 “(1) IN GENERAL.—This section shall apply to
3 a compensating coverage payment made by an em-
4 ployer for an employee’s benefit only if—

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

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

13 “(C) the employer permits the election re-
14 ferred to in subsection (b) to be made by em-
15 ployees—

16 “(i) at the commencement of employ-
17 ment with the employer, and

18 “(ii) during open enrollment periods
19 (not less frequently than annually) of at
20 least 30 days.

21 “(2) EXCEPTION FOR CERTAIN EMPLOYEES.—

22 Paragraph (1) shall not apply to—

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

1 such employee or of an employer of such em-
2 ployee's spouse,

3 “(B) any employee who normally works
4 less than 25 hours per week,

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

8 “(D) any employee who has not attained
9 age 21, and

10 “(E) except to the extent provided in regu-
11 lations, any employee who is included in a unit
12 of employees covered by an agreement which
13 the Secretary of Labor finds to be a collective
14 bargaining agreement between employee rep-
15 resentatives and the employer.

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

20 “(4) EMPLOYER HEALTH PLAN CONTRIBU-
21 TION.—For purposes of this section—

22 “(A) IN GENERAL.—The term ‘employer
23 health plan contribution’ means the applicable
24 premium for the employee reduced by the em-
25 ployee's share of such premium.

1 “(B) APPLICABLE PREMIUM.—Except as
2 provided in subparagraph (D), the term ‘appli-
3 cable premium’ means an amount which is not
4 less than 98 percent of—

5 “(i) the applicable premium (as de-
6 fined in section 4980B(f)(4)) for the em-
7 ployee, or

8 “(ii) if an election under subpara-
9 graph (D) is in effect with respect to an
10 employee, the applicable premium deter-
11 mined under subparagraph (D).

12 “(C) EMPLOYEE’S SHARE.—The term ‘em-
13 ployee’s share’ means, with respect to the appli-
14 cable premium for any employee, the amount of
15 the cost to the plan which is paid by the simi-
16 larly situated beneficiaries who are taken into
17 account in determining such premium for such
18 employee.

19 “(D) AUTHORITY TO USE AGE, SEX, AND
20 GEOGRAPHY IN DETERMINING CONTRIBU-
21 TION.—

22 “(i) IN GENERAL.—An employer may
23 elect to determine the applicable premium
24 for an employee on an actuarial basis tak-
25 ing into account age, sex, and geography of

1 the employee and similarly situated bene-
2 ficiaries.

3 “(ii) DETERMINATION OF EMPLOY-
4 EE’S SHARE.—In the case of an employer
5 who determines the applicable premium
6 under clause (i), the employee’s share of
7 such premium shall be the same percent-
8 age of such premium as the employee’s
9 share of the applicable premium deter-
10 mined without regard to clause (i).

11 “(iii) CONSISTENCY REQUIRED.—

12 “(I) IN GENERAL.—Except as
13 provided in subclause (III), an em-
14 ployer may determine the applicable
15 premium under this subparagraph for
16 any employee only if such employer,
17 and all other employers which are
18 members of any controlled group
19 which includes such employer, elect to
20 determine the applicable premium
21 under this subparagraph for all their
22 employees.

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

1 52 or subsection (m) or (o) of section
 2 414 shall be treated as members of a
 3 controlled group for purposes of sub-
 4 clause (I).

5 “(III) TREATMENT OF SEPARATE
 6 LINES OF BUSINESS.—If an employer
 7 is treated under section 414(r) as op-
 8 erating separate lines of business dur-
 9 ing any taxable year, subclause (I)
 10 shall not apply to employees employed
 11 in such separate lines of business.

12 “(f) SPECIAL RULE FOR ARCHER MSAS AND
 13 HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—Sections
 14 220(b)(5) and 223(b)(4) shall not apply to an employer
 15 contribution which is excludable from gross income under
 16 subsection (a).

17 “(g) EXCLUSION APPLICABLE IN DETERMINING EM-
 18 PLOYMENT TAX LIABILITY.—The exclusion under this
 19 section shall be treated for purposes of subtitle C in the
 20 same manner as the exclusion under section 106.”

21 (b) EMPLOYER HEALTH PLAN CONTRIBUTION TO BE
 22 REPORTED ON W-2.—Subsection (a) of section 6051 of
 23 such Code (relating to receipts to employees) is amended
 24 by striking “and” at the end of paragraph (12), by strik-
 25 ing the period at the end of paragraph (13) and inserting

1 a comma, and by inserting after paragraph (13) the fol-
 2 lowing new paragraphs:

3 “(14) the amount of the employer health plan
 4 contribution (as defined in section 139(c)(3)), and
 5 “(15) the amount of compensating coverage
 6 payment (as defined in section 139(c)(1)).”

7 (c) CLERICAL AMENDMENT.—The table of sections
 8 for such part III is amended by inserting after the item
 9 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.”.

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

13 **TITLE VI—PATIENT ACCESS TO** 14 **INFORMATION**

15 **SEC. 601. PATIENT ACCESS TO INFORMATION REGARDING** 16 **PLAN COVERAGE, MANAGED CARE PROCE-** 17 **DURES, HEALTH CARE PROVIDERS, AND** 18 **QUALITY OF MEDICAL CARE.**

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

1 **“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARD-**
2 **ING PLAN COVERAGE, MANAGED CARE PRO-**
3 **CEDURES, HEALTH CARE PROVIDERS, AND**
4 **QUALITY OF MEDICAL CARE.**

5 “(a) **DISCLOSURE REQUIREMENT.**—Each health in-
6 surance issuer offering health insurance coverage in con-
7 nection with a group health plan shall provide the adminis-
8 trator of such plan on a timely basis with the information
9 necessary to enable the administrator to include in the
10 summary plan description of the plan required under sec-
11 tion 102 of the Employee Retirement Income Security Act
12 of 1974 (or each summary plan description in any case
13 in which different summary plan descriptions are appro-
14 priate under part 1 of subtitle B of title I of such Act
15 for different options of coverage) the information required
16 under subsections (b), (c), (d), and (e)(2)(A). To the ex-
17 tent that any such issuer provides such information on a
18 timely basis to plan participants and beneficiaries, the re-
19 quirements of this subsection shall be deemed satisfied in
20 the case of such plan with respect to such information.

21 “(b) **PLAN BENEFITS.**—The information required
22 under subsection (a) includes the following:

23 “(1) **COVERED ITEMS AND SERVICES.**—

24 “(A) **CATEGORIZATION OF INCLUDED BEN-**
25 **EFITS.**—A description of covered benefits, cat-
26 egorized by—

1 “(i) types of items and services (in-
2 cluding any special disease management
3 program); and

4 “(ii) types of health care professionals
5 providing such items and services.

6 “(B) EMERGENCY MEDICAL CARE.—A de-
7 scription of the extent to which the coverage in-
8 cludes emergency medical care (including the
9 extent to which the coverage provides for access
10 to urgent care centers), and any definitions pro-
11 vided under in connection with such coverage
12 for the relevant coverage terminology referring
13 to such care.

14 “(C) PREVENTATIVE SERVICES.—A de-
15 scription of the extent to which the coverage in-
16 cludes benefits for preventative services.

17 “(D) DRUG FORMULARIES.—A description
18 of the extent to which covered benefits are de-
19 termined by the use or application of a drug
20 formulary and a summary of the process for de-
21 termining what is included in such formulary.

22 “(E) COBRA CONTINUATION COV-
23 ERAGE.—A description of the benefits available
24 under the coverage provided pursuant to part 6

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

3 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-
4 TIONS ON COVERED BENEFITS.—

5 “(A) CATEGORIZATION OF EXCLUDED
6 BENEFITS.—A description of benefits specifi-
7 cally excluded from coverage, categorized by
8 types of items and services.

9 “(B) UTILIZATION REVIEW AND
10 PREAUTHORIZATION REQUIREMENTS.—Whether
11 coverage for medical care is limited or excluded
12 on the basis of utilization review or
13 preauthorization requirements.

14 “(C) LIFETIME, ANNUAL, OR OTHER PE-
15 RIOD LIMITATIONS.—A description of the cir-
16 cumstances under which, and the extent to
17 which, coverage is subject to lifetime, annual, or
18 other period limitations, categorized by types of
19 benefits.

20 “(D) CUSTODIAL CARE.—A description of
21 the circumstances under which, and the extent
22 to which, the coverage of benefits for custodial
23 care is limited or excluded, and a statement of
24 the definition used in connection with such cov-
25 erage for custodial care.

1 “(E) EXPERIMENTAL TREATMENTS.—

2 Whether coverage for any medical care is lim-
3 ited or excluded because it constitutes experi-
4 mental treatment or technology, and any defini-
5 tions provided in connection with such coverage
6 for the relevant plan terminology referring to
7 such limited or excluded care.

8 “(F) MEDICAL APPROPRIATENESS OR NE-

9 CESSITY.—Whether coverage for medical care
10 may be limited or excluded by reason of a fail-
11 ure to meet the plan’s requirements for medical
12 appropriateness or necessity, and any defini-
13 tions provided in connection with such coverage
14 for the relevant coverage terminology referring
15 to such limited or excluded care.

16 “(G) SECOND OR SUBSEQUENT OPIN-

17 IONS.—A description of the circumstances
18 under which, and the extent to which, coverage
19 for second or subsequent opinions is limited or
20 excluded.

21 “(H) SPECIALTY CARE.—A description of

22 the circumstances under which, and the extent
23 to which, coverage of benefits for specialty care
24 is conditioned on referral from a primary care
25 provider.

1 “(I) CONTINUITY OF CARE.—A description
2 of the circumstances under which, and the ex-
3 tent to which, coverage of items and services
4 provided by any health care professional is lim-
5 ited or excluded by reason of the departure by
6 the professional from any defined set of pro-
7 viders.

8 “(J) RESTRICTIONS ON COVERAGE OF
9 EMERGENCY SERVICES.—A description of the
10 circumstances under which, and the extent to
11 which, the coverage, in including emergency
12 medical care furnished to a participant or bene-
13 ficiary of the plan imposes any financial respon-
14 sibility described in subsection (c) on partici-
15 pants or beneficiaries or limits or conditions
16 benefits for such care subject to any other term
17 or condition of such coverage.

18 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-
19 ITIES.—The information required under subsection (a) in-
20 cludes an explanation of—

21 “(1) a participant’s financial responsibility for
22 payment of premiums, coinsurance, copayments,
23 deductibles, and any other charges; and

24 “(2) the circumstances under which, and the
25 extent to which, the participant’s financial responsi-

1 bility described in paragraph (1) may vary, including
2 any distinctions based on whether a health care pro-
3 vider from whom covered benefits are obtained is in-
4 cluded in a defined set of providers.

5 “(d) ACCOUNTABILITY.—The information required
6 under subsection (a) includes a description of the legal re-
7 course options available for participants and beneficiaries
8 under the plan including—

9 “(1) the preemption that applies under section
10 514 of the Employee Retirement Income Security
11 Act of 1974 (29 U.S.C. 1144) to certain actions
12 arising out of the provision of health benefits;

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

20 “(3) the extent to which coverage decisions
21 made by the plan are subject to internal review or
22 any external review and the proper time frames
23 under which such reviews may be requested and con-
24 ducted.

25 “(e) INFORMATION AVAILABLE ON REQUEST.—

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

3 “(A) IN GENERAL.—A group health plan
4 (and a health insurance issuer offering health
5 insurance coverage in connection with a group
6 health plan) shall, upon written request (made
7 not more frequently than annually), make avail-
8 able to participants and beneficiaries, in a gen-
9 erally recognized electronic format, the fol-
10 lowing information:

11 “(i) the latest summary plan descrip-
12 tion, including the latest summary of ma-
13 terial modifications; and

14 “(ii) the actual plan provisions setting
15 forth the benefits available under the plan,
16 to the extent such information relates to the
17 coverage options under the plan available to the
18 participant or beneficiary. A reasonable charge
19 may be made to cover the cost of providing
20 such information in such generally recognized
21 electronic format. The Secretary may by regula-
22 tion prescribe a maximum amount which will
23 constitute a reasonable charge under the pre-
24 ceding sentence.

1 “(B) ALTERNATIVE ACCESS.—The require-
2 ments of this paragraph may be met by making
3 such information generally available (rather
4 than upon request) on the Internet or on a pro-
5 prietary computer network in a format which is
6 readily accessible to participants and bene-
7 ficiaries.

8 “(2) ADDITIONAL INFORMATION TO BE PRO-
9 VIDED ON REQUEST.—

10 “(A) INCLUSION IN SUMMARY PLAN DE-
11 SCRIPTION OF SUMMARY OF ADDITIONAL IN-
12 FORMATION.—The information required under
13 subsection (a) includes a summary description
14 of the types of information required by this
15 subsection to be made available to participants
16 and beneficiaries on request.

17 “(B) INFORMATION REQUIRED FROM
18 PLANS AND ISSUERS ON REQUEST.—In addition
19 to information required to be included in sum-
20 mary plan descriptions under this subsection, a
21 group health plan (and a health insurance
22 issuer offering health insurance coverage in
23 connection with a group health plan) shall pro-
24 vide the following information to a participant
25 or beneficiary on request:

1 “(i) NETWORK CHARACTERISTICS.—If
2 the plan (or issuer) utilizes a defined set of
3 providers under contract with the plan (or
4 issuer), a detailed list of the names of such
5 providers and their geographic location, set
6 forth separately with respect to primary
7 care providers and with respect to special-
8 ists.

9 “(ii) CARE MANAGEMENT INFORMA-
10 TION.—A description of the circumstances
11 under which, and the extent to which, the
12 plan has special disease management pro-
13 grams or programs for persons with dis-
14 abilities, indicating whether these pro-
15 grams are voluntary or mandatory and
16 whether a significant benefit differential
17 results from participation in such pro-
18 grams.

19 “(iii) INCLUSION OF DRUGS AND
20 BIOLOGICALS IN FORMULARIES.—A state-
21 ment of whether a specific drug or biologi-
22 cal is included in a formulary used to de-
23 termine benefits under the plan and a de-
24 scription of the procedures for considering
25 requests for any patient-specific waivers.

1 “(iv) PROCEDURES FOR DETERMINING
2 EXCLUSIONS BASED ON MEDICAL NECES-
3 SITY OR EXPERIMENTAL TREATMENTS.—
4 Upon receipt by the participant or bene-
5 ficiary of any notification of an adverse
6 coverage decision based on a determination
7 relating to medical necessity or an experi-
8 mental treatment or technology, a descrip-
9 tion of the procedures and medically-based
10 criteria used in such decision.

11 “(v) PREAUTHORIZATION AND UTILI-
12 ZATION REVIEW PROCEDURES.—Upon re-
13 ceipt by the participant or beneficiary of
14 any notification of an adverse coverage de-
15 cision, a description of the basis on which
16 any preauthorization requirement or any
17 utilization review requirement has resulted
18 in such decision.

19 “(vi) ACCREDITATION STATUS OF
20 HEALTH INSURANCE ISSUERS AND SERV-
21 ICE PROVIDERS.—A description of the ac-
22 creditation and licensing status (if any) of
23 each health insurance issuer offering
24 health insurance coverage in connection
25 with the plan and of any utilization review

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

4 “(vii) MEASURES OF ENROLLEE SAT-
5 ISFACTION.—The latest information (if
6 any) maintained by the plan, or by any
7 health insurance issuer offering health in-
8 surance coverage in connection with the
9 plan, relating to enrollee satisfaction.

10 “(viii) QUALITY PERFORMANCE MEAS-
11 URES.—The latest information (if any)
12 maintained by the plan, or by any health
13 insurance issuer offering health insurance
14 coverage in connection with the plan, relat-
15 ing to quality of performance of the deliv-
16 ery of medical care with respect to cov-
17 erage options offered under the plan and
18 of health care professionals and facilities
19 providing medical care under the plan.

20 “(C) INFORMATION REQUIRED FROM
21 HEALTH CARE PROFESSIONALS ON REQUEST.—
22 Any health care professional treating a partici-
23 pant or beneficiary under a group health plan
24 shall provide to the participant or beneficiary,
25 on request, a description of his or her profes-

1 sional qualifications (including board certifi-
2 cation status, licensing status, and accreditation
3 status, if any), privileges, and experience and a
4 general description by category (including sal-
5 ary, fee-for-service, capitation, and such other
6 categories as may be specified in regulations of
7 the Secretary) of the applicable method by
8 which such professional is compensated in con-
9 nection with the provision of such medical care.

10 “(D) INFORMATION REQUIRED FROM
11 HEALTH CARE FACILITIES ON REQUEST.—Any
12 health care facility from which a participant or
13 beneficiary has sought treatment under a group
14 health plan shall provide to the participant or
15 beneficiary, on request, a description of the fa-
16 cility’s corporate form or other organizational
17 form and all forms of licensing and accredita-
18 tion status (if any) assigned to the facility by
19 standard-setting organizations.

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

1 nection with a group health plan) shall, upon written re-
2 quest (made not more frequently than annually), make
3 available to a participant (and an employee who, under
4 the terms of the plan, is eligible for coverage but not en-
5 rolled) in connection with a period of enrollment the sum-
6 mary plan description for any coverage option under the
7 plan under which the participant is eligible to enroll and
8 any information described in clauses (i), (ii), (iii), (vi),
9 (vii), and (viii) of subsection (e)(2)(B).

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

18 “(1) by inclusion of information in publications
19 broadly distributed by plan sponsors, employers, or
20 employee organizations;

21 “(2) by electronic means of communication (in-
22 cluding the Internet or proprietary computer net-
23 works in a format which is readily accessible to par-
24 ticipants);

1 “(3) by timely informing participants who,
2 under an ongoing program maintained under the
3 plan, have submitted their names for such notifica-
4 tion; or

5 “(4) by any other reasonable means of timely
6 informing plan participants.”.

7 **SEC. 602. EFFECTIVE DATE.**

8 (a) IN GENERAL.—The amendments made by section
9 601 shall apply with respect to plan years beginning on
10 or after January 1 of the second calendar year following
11 the date of the enactment of this Act. The Secretary shall
12 first issue all regulations necessary to carry out the
13 amendments made by section 601 before such date.

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

