

113TH CONGRESS
1ST SESSION

H. R. 2688

To improve healthcare-related, tax-preferred savings accounts and to provide for cooperative governing of individual and group health insurance coverage across State lines, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 15, 2013

Mr. ROSS introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, 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 improve healthcare-related, tax-preferred savings accounts and to provide for cooperative governing of individual and group health insurance coverage across State lines, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Providing Accountability and Transparency to
6 Incentivize Economically Necessary Transitions in Health

1 Care Act of 2013” or the “PATIENT’s Health Care Act
2 of 2013”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTHCARE-RELATED SAVINGS ACCOUNTS

- Sec. 101. Deduction of premiums for high deductible health plans.
- Sec. 102. Repeal of high deductible health plan requirement.
- Sec. 103. Increase in deductible HSA contribution limitations.
- Sec. 104. Medicare eligible individuals eligible to contribute to HSA.
- Sec. 105. HSA rollover to Medicare Advantage MSA.
- Sec. 106. One-time transfer of flexible spending arrangement balance to health savings account in case of separation from employment.
- Sec. 107. Payment of high deductible health plan premiums from HSA.
- Sec. 108. Repeal of disqualification of expenses for over-the-counter drugs under certain accounts and arrangements.
- Sec. 109. Payment of long-term care premiums from health flexible spending arrangement.
- Sec. 110. Allowing MSA and HSA rollover to adult child of account holder.
- Sec. 111. Disposition of unused health benefits in cafeteria plans and flexible spending arrangements.
- Sec. 112. Permitting beneficiary contributions to Medicare Advantage MSA.
- Sec. 113. Child health savings account.

TITLE II—HEALTH INSURANCE PROVISIONS

- Sec. 201. Cooperative governing of individual and group health insurance coverage.
- Sec. 202. Reauthorization of the Preexisting Condition Insurance Plan (PCIP) Program.

5 **TITLE I—HEALTHCARE-RELATED** 6 **SAVINGS ACCOUNTS**

7 **SEC. 101. DEDUCTION OF PREMIUMS FOR HIGH DEDUCT-** 8 **IBLE HEALTH PLANS.**

9 (a) IN GENERAL.—Part VII of subchapter B of chap-
10 ter 1 of the Internal Revenue Code of 1986 is amended
11 by redesignating section 224 as section 225 and by insert-
12 ing after section 223 the following new section:

1 **“SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH**
2 **PLANS.**

3 “(a) DEDUCTION ALLOWED.—In the case of an indi-
4 vidual, there shall be allowed as a deduction for the tax-
5 able year the aggregate amount paid by such individual
6 as premiums under a high deductible health plan with re-
7 spect to months during such year for which such indi-
8 vidual is an eligible individual with respect to such health
9 plan.

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

11 “(1) ELIGIBLE INDIVIDUAL.—

12 “(A) IN GENERAL.—The term ‘eligible in-
13 dividual’ means, with respect to any month, any
14 individual if—

15 “(i) such individual is covered under a
16 high deductible health plan as of the 1st
17 day of such month, and

18 “(ii) such individual is not, while cov-
19 ered under a high deductible health plan,
20 covered under any health plan—

21 “(I) which is not a high deduct-
22 ible health plan, and

23 “(II) which provides coverage for
24 any benefit which is covered under the
25 high deductible health plan.

1 “(B) CERTAIN COVERAGE DIS-
2 REGARDED.—Subparagraph (A)(ii) shall be ap-
3 plied without regard to—

4 “(i) coverage for any benefit provided
5 by permitted insurance,

6 “(ii) coverage (whether through insur-
7 ance or otherwise) for accidents, disability,
8 dental care, vision care, or long-term care,
9 and

10 “(iii) coverage under a health flexible
11 spending arrangement during any period
12 immediately following the end of a plan
13 year of such arrangement during which un-
14 used benefits or contributions remaining at
15 the end of such plan year may be paid or
16 reimbursed to plan participants for quali-
17 fied benefit expenses incurred during such
18 period if—

19 “(I) the balance in such arrange-
20 ment at the end of such plan year is
21 zero, or

22 “(II) the individual is making a
23 qualified HSA distribution (as defined
24 in section 106(e)) in an amount equal
25 to the remaining balance in such ar-

1 rangement as of the end of such plan
2 year, in accordance with rules pre-
3 scribed by the Secretary.

4 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—

5 “(A) IN GENERAL.—The term ‘high de-
6 ductible health plan’ means a health plan—

7 “(i) which has an annual deductible
8 which is not less than—

9 “(I) \$1,000 for self-only cov-
10 erage, and

11 “(II) twice the dollar amount in
12 subclause (I) for family coverage, and

13 “(ii) the sum of the annual deductible
14 and the other annual out-of-pocket ex-
15 penses required to be paid under the plan
16 (other than for premiums) for covered ben-
17 efits does not exceed—

18 “(I) \$5,000 for self-only cov-
19 erage, and

20 “(II) twice the dollar amount in
21 subclause (I) for family coverage.

22 “(B) EXCLUSION OF CERTAIN PLANS.—

23 Such term does not include a health plan if
24 substantially all of its coverage is described in
25 paragraph (1)(B).

1 “(C) SAFE HARBOR FOR ABSENCE OF PRE-
 2 VENTIVE CARE DEDUCTIBLE.—A plan shall not
 3 fail to be treated as a high deductible health
 4 plan by reason of failing to have a deductible
 5 for preventive care (within the meaning of sec-
 6 tion 1871 of the Social Security Act, except as
 7 otherwise provided by the Secretary).

8 “(D) SPECIAL RULE FOR ANNUAL OUT-OF-
 9 POCKET LIMITATION FOR NETWORK PLANS.—In
 10 the case of a plan using a network of providers,
 11 such plan shall not fail to be treated as a high
 12 deductible health plan by reason of having an
 13 out-of-pocket limitation for services provided
 14 outside of such network which exceeds the ap-
 15 plicable limitation under subparagraph (A)(ii).

16 “(3) PERMITTED INSURANCE.—The term ‘per-
 17 mitted insurance’ means—

18 “(A) insurance if substantially all of the
 19 coverage provided under such insurance relates
 20 to—

21 “(i) liabilities incurred under workers’
 22 compensation laws,

23 “(ii) tort liabilities,

24 “(iii) liabilities relating to ownership
 25 or use of property, or

1 “(iv) such other similar liabilities as
2 the Secretary may specify by regulations,

3 “(B) insurance for a specified disease or
4 illness, and

5 “(C) insurance paying a fixed amount per
6 day (or other period) of hospitalization.

7 “(4) FAMILY COVERAGE.—The term ‘family
8 coverage’ means any coverage other than self-only
9 coverage.

10 “(c) SPECIAL RULES.—

11 “(1) DEDUCTION ALLOWABLE FOR ONLY 1
12 PLAN.—For purposes of this section, in the case of
13 an individual covered by more than 1 high deductible
14 health plan for any month, the individual may only
15 take into account amounts paid for 1 of such plans
16 for such month.

17 “(2) EMPLOYER PROVIDED COVERAGE.—

18 “(A) IN GENERAL.—No deduction shall be
19 allowed to an individual under subsection (a)
20 for any amount paid for coverage under a high
21 deductible health plan for a month if that indi-
22 vidual participates in any coverage for such
23 month that is excluded (in whole or in part)
24 from the gross income of the individual or the
25 individual’s spouse under section 106.

1 “(B) CAFETERIA PLANS, ETC.—Employer
2 contributions to a cafeteria plan or a flexible
3 spending or similar arrangement which are ex-
4 cluded from gross income under section 106
5 shall be treated for purposes of this section as
6 paid by the employer.

7 “(3) CONTRIBUTIONS TO HEALTH SAVINGS AC-
8 COUNT REQUIRED.—A deduction shall not be al-
9 lowed under subsection (a) for a taxable year with
10 respect to such individual if such individual is not al-
11 lowed a deduction under section 223 for such tax-
12 able year.

13 “(4) MEDICAL AND HEALTH SAVINGS AC-
14 COUNTS.—Subsection (a) shall not apply with re-
15 spect to any amount which is paid or distributed out
16 of an Archer MSA or a health savings account which
17 is not included in gross income under section 220(f)
18 or 223(f), as the case may be.

19 “(5) COORDINATION WITH DEDUCTION FOR
20 HEALTH INSURANCE OF SELF-EMPLOYED INDIVID-
21 UALS.—The amount taken into account by the tax-
22 payer in computing the deduction under section
23 162(l) shall not be taken into account under this
24 section.

1 “(6) COORDINATION WITH MEDICAL EXPENSE
 2 DEDUCTION.—The amount taken into account by
 3 the taxpayer in computing the deduction under this
 4 section shall not be taken into account under section
 5 213.”.

6 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL
 7 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
 8 of section 62 of such Code is amended by inserting after
 9 paragraph (21) the following new paragraph:

10 “(22) PREMIUMS FOR HIGH DEDUCTIBLE
 11 HEALTH PLANS.—The deduction allowed by section
 12 224.”.

13 (c) CLERICAL AMENDMENT.—The table of sections
 14 for part VII of subchapter B of chapter 1 of such Code
 15 is amended by striking the last item and inserting the fol-
 16 lowing new items:

“Sec. 224. Premiums for high deductible health plans.
 “Sec. 225. Cross reference.”.

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to taxable years beginning after
 19 December 31, 2013.

20 **SEC. 102. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN RE-**
 21 **QUIREMENT.**

22 (a) IN GENERAL.—Subsection (a) of section 223 of
 23 such Code is amended to read as follows:

1 “(a) DEDUCTION ALLOWED.—In the case of an indi-
 2 vidual, there shall be allowed as a deduction for a taxable
 3 year an amount equal to the aggregate amount paid in
 4 cash during such taxable year by or on behalf of such indi-
 5 vidual to a health savings account of such individual.”.

6 (b) CONFORMING AMENDMENTS.—

7 (1) Section 223 of such Code is amended by
 8 striking subsection (c) and redesignating subsections
 9 (d) through (h) as subsections (c) through (g), re-
 10 spectively.

11 (2) Section 223(b) of such Code is amended by
 12 striking paragraph (8).

13 (3) Subparagraph (A) of section 223(c)(1) of
 14 such Code (as redesignated by paragraph (1)) is
 15 amended—

16 (A) by striking “subsection (f)(5)” and in-
 17 serting “subsection (e)(5)”, and

18 (B) in clause (ii)—

19 (i) by striking “the sum of—” and all
 20 that follows and inserting “the dollar
 21 amount in effect under subsection (b)(1).”.

22 (4) Section 223(f)(1) of such Code (as redesign-
 23 ated by paragraph (1)) is amended by striking
 24 “Each dollar amount in subsections (b)(2) and
 25 (c)(2)(A)” and inserting “In the case of a taxable

1 year beginning after December 31, 2010, each dollar
2 amount in subsection (b)(1)”.

3 (5) Section 26(b)(U) of such Code is amended
4 by striking “section 223(f)(4)” and inserting “sec-
5 tion 223(e)(4)”.

6 (6) Sections 35(g)(3), 220(f)(5)(A),
7 848(e)(1)(v), 4973(a)(5), and 6051(a)(12) of such
8 Code are each amended by striking “section 223(d)”
9 each place it appears and inserting “section 223(c)”.

10 (7) Section 106(d)(1) of such Code is amend-
11 ed—

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

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

16 (8) Section 408(d)(9) of such Code is amend-
17 ed—

18 (A) in subparagraph (A) by striking “who
19 is an eligible individual (as defined in section
20 223(c)) and”, and

21 (B) in subparagraph (C) by striking “com-
22 puted on the basis of the type of coverage under
23 the high deductible health plan covering the in-
24 dividual at the time of the qualified HSA fund-
25 ing distribution”.

1 (9) Section 877A(g)(6) of such Code is amend-
2 ed by striking “223(f)(4)” and inserting
3 “223(e)(4)”.

4 (10) Section 4973(g) of such Code is amend-
5 ed—

6 (A) by striking “section 223(d)” and in-
7 serting “section 223(c)”,

8 (B) in paragraph (2), by striking “section
9 223(f)(2)” and inserting “section 223(e)(2)”,
10 and

11 (C) by striking “section 223(f)(3)” and in-
12 serting “section 223(e)(3)”.

13 (11) Section 4975 of such Code is amended—

14 (A) in subsection (c)(6)—

15 (i) by striking “section 223(d)” and
16 inserting “section 223(c)”, and

17 (ii) by striking “section 223(e)(2)”
18 and inserting “section 223(d)(2)”, and

19 (B) in subsection (e)(1)(E), by striking
20 “section 223(d)” and inserting “section
21 223(c)”.

22 (12) Section 6693(a)(2)(C) of such Code is
23 amended by striking “section 223(h)” and inserting
24 “section 223(g)”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 2011.

4 **SEC. 103. INCREASE IN DEDUCTIBLE HSA CONTRIBUTION**
 5 **LIMITATIONS.**

6 (a) IN GENERAL.—Paragraph (1) of section 223(b)
 7 of the Internal Revenue Code of 1986 is amended by strik-
 8 ing “the sum of the monthly” and all that follows through
 9 “eligible individual” and inserting “\$10,000 (\$20,000 in
 10 the case of a joint return)”.

11 (b) ADDITIONAL CONTRIBUTIONS.—Paragraph (3) of
 12 section 223(b) is amended to read as follows:

13 “(3) ADDITIONAL CONTRIBUTIONS FOR INDIV-
 14 IDUALS BETWEEN 55 AND 65.—In the case of an in-
 15 dividual who has attained the age of 55, but has not
 16 attained the age of 66, before the close of the tax-
 17 able year, the limitation under paragraph (1) shall
 18 be increased by \$10,000.”.

19 (c) CONFORMING AMENDMENTS.—

20 (1) Section 223(b) of such Code, as amended by
 21 this Act, is amended by striking paragraphs (2) and
 22 (5) and by redesignating paragraphs (3), (4), (6),
 23 and (7) as paragraphs (2), (3), (4), and (5), respec-
 24 tively.

1 (2) Section 223(c)(1)(A)(ii) of such Code (as
 2 redesignated by this Act) is amended by striking
 3 “the sum of—” and all that follows and inserting
 4 “the dollar amount in effect under subsection
 5 (b)(1).”.

6 (3) Section 223(f)(1) of such Code (as redesign-
 7 nated by this Act) is amended by striking “Each
 8 dollar amount in subsections (b)(2) and (c)(2)(A)”
 9 and inserting “In the case of a taxable year begin-
 10 ning after December 31, 2013, each dollar amount
 11 in subsection (b)(1)”.

12 (4) Paragraph (3) of section 223(b) of such
 13 Code (as redesignated by paragraph (1)) is amended
 14 by striking the last sentence.

15 (d) EFFECTIVE DATE.—The amendments made by
 16 this section shall apply to taxable years beginning after
 17 December 31, 2013.

18 **SEC. 104. MEDICARE ELIGIBLE INDIVIDUALS ELIGIBLE TO**
 19 **CONTRIBUTE TO HSA.**

20 (a) Subsection (b) of section 223 of the Internal Rev-
 21 enue Code of 1986, as amended by this Act, is amended
 22 by striking paragraph (4).

23 (b) EFFECTIVE DATE.—The amendments made by
 24 this section shall apply to taxable years beginning after
 25 December 31, 2013.

1 **SEC. 105. HSA ROLLOVER TO MEDICARE ADVANTAGE MSA.**

2 (a) IN GENERAL.—Paragraph (2) of section 138(b)
 3 of the Internal Revenue Code of 1986 is amended by strik-
 4 ing “or” at the end of subparagraph (A), by adding “or”
 5 at the end of subparagraph (C), and by adding at the end
 6 the following new subparagraph:

7 “(C) a HSA rollover contribution described
 8 in subsection (c)(5),”.

9 (b) HSA ROLLOVER CONTRIBUTION.—Subsection (c)
 10 of section 138 of such Code is amended by adding at the
 11 end the following new paragraph:

12 “(5) ROLLOVER CONTRIBUTION.—An amount is
 13 described in this paragraph as a rollover contribu-
 14 tion if it meets the requirements of subparagraphs
 15 (A) and (B).

16 “(A) IN GENERAL.—The requirements of
 17 this subparagraph are met in the case of an
 18 amount paid or distributed from a health sav-
 19 ings account to the account beneficiary to the
 20 extent the amount received is paid into a Medi-
 21 care Advantage MSA of such beneficiary not
 22 later than the 60th day after the day on which
 23 the beneficiary receives the payment or distribu-
 24 tion.

25 “(B) LIMITATION.—This paragraph shall
 26 not apply to any amount described in subpara-

1 graph (A) received by an individual from a
 2 health savings account if, at any time during
 3 the 1-year period ending on the day of such re-
 4 ceipt, such individual received any other amount
 5 described in subparagraph (A) from a health
 6 savings account which was not includible in the
 7 individual's gross income because of the appli-
 8 cation of section 223(e)(5)(A).”.

9 (c) CONFORMING AMENDMENT.—Subparagraph (A)
 10 of section 223(e)(5) of such Code, as amended by this Act,
 11 is amended by inserting “or Medicare Advantage MSA”
 12 after “into a health savings account”.

13 (d) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply to taxable years beginning after
 15 December 31, 2013.

16 **SEC. 106. ONE-TIME TRANSFER OF FLEXIBLE SPENDING AR-**
 17 **RANGEMENT BALANCE TO HEALTH SAVINGS**
 18 **ACCOUNT IN CASE OF SEPARATION FROM**
 19 **EMPLOYMENT.**

20 (a) IN GENERAL.—Section 125 of the Internal Rev-
 21 enue Code of 1986 is amended by redesignating subsection
 22 (j) as subsection (k) and by inserting after subsection (i)
 23 the following new subsection:

1 “(j) ONE-TIME TRANSFER OF REMAINING BALANCE
 2 IN HEALTH FLEXIBLE SPENDING ARRANGEMENT AFTER
 3 SEPARATION FROM EMPLOYMENT.—

4 “(1) IN GENERAL.—For purposes of this title,
 5 a plan shall not fail to be treated as a health flexible
 6 spending arrangement solely because a participant
 7 may, in connection with separation from employment
 8 with the employer, direct amounts in the partici-
 9 pant’s account under such arrangement to be con-
 10 tributed on behalf of the participant to a health sav-
 11 ings account (as defined in section 223(c)) main-
 12 tained for the benefit of the participant.”.

13 (b) CONFORMING AMENDMENT.—Section
 14 223(c)(1)(A) of such Code, as amended by this Act, is
 15 amended by striking “or section 220(f)(5)” and inserting
 16 “, section 125(j), or section 220(f)(5)”.

17 (c) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to taxable years beginning after
 19 December 31, 2013.

20 **SEC. 107. PAYMENT OF HIGH DEDUCTIBLE HEALTH PLAN**
 21 **PREMIUMS FROM HSA.**

22 (a) IN GENERAL.—Subparagraph (B) of section
 23 223(c)(2) of such Code, as amended by this Act, is amend-
 24 ed by inserting “other than a high deductible plan (as de-
 25 fined in section 224(b)(2))” before the period at the end.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 2013.

4 **SEC. 108. REPEAL OF DISQUALIFICATION OF EXPENSES**
 5 **FOR OVER-THE-COUNTER DRUGS UNDER**
 6 **CERTAIN ACCOUNTS AND ARRANGEMENTS.**

7 (a) HSAs.—Subparagraph (A) of section 223(c)(2)
 8 of the Internal Revenue Code of 1986, as amended by this
 9 Act, is amended by striking the last sentence.

10 (b) ARCHER MSAs.—Subparagraph (A) of section
 11 220(d)(2) of such Code is amended by striking the last
 12 sentence.

13 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
 14 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-
 15 tion 106 of such Code is amended by striking subsection
 16 (f).

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to expenses incurred after Decem-
 19 ber 31, 2013.

20 **SEC. 109. PAYMENT OF LONG-TERM CARE PREMIUMS FROM**
 21 **HEALTH FLEXIBLE SPENDING ARRANGE-**
 22 **MENT.**

23 (a) IN GENERAL.—Section 125 of the Internal Rev-
 24 enue Code of 1986, as amended by this Act, is amended

1 by inserting after subsection (h) the following new sub-
 2 section:

3 “(i) PAYMENT OF LONG-TERM CARE PREMIUMS
 4 FROM HEALTH FLEXIBLE SPENDING ARRANGEMENT.—

5 “(1) IN GENERAL.—No payment for insurance
 6 may be made from a health flexible spending ar-
 7 rangement.

8 “(2) LONG-TERM CARE INSURANCE.—Para-
 9 graph (1) shall not apply to any expense for cov-
 10 erage under a qualified long-term care insurance
 11 contract (as defined in section 7702B(b)).”.

12 (b) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to taxable years beginning after
 14 December 31, 2013.

15 **SEC. 110. ALLOWING MSA AND HSA ROLLOVER TO ADULT**
 16 **CHILD OF ACCOUNT HOLDER.**

17 (a) MSAs.—

18 (1) IN GENERAL.—Subparagraph (A) of section
 19 220(f)(8) of the Internal Revenue Code of 1986 (re-
 20 lating to treatment after death of account holder) is
 21 amended—

22 (A) by inserting “or adult child” after
 23 “surviving spouse”,

24 (B) by inserting “or adult child, as the
 25 case may be,” after “the spouse”, and

1 (C) by inserting “or adult child” after
2 “spouse” in the heading thereof.

3 (2) ADULT CHILD DEFINED.—Paragraph (8) of
4 section 220(f) of such Code is amended by adding
5 at the end the following new subparagraph:

6 “(C) ADULT CHILD.—For purposes of this
7 paragraph, the term ‘adult child’ means an in-
8 dividual—

9 “(i) who is a child of the deceased in-
10 dividual, and

11 “(ii) with respect to whom a deduc-
12 tion under section 151 would not be allow-
13 able to another taxpayer for a taxable year
14 beginning in the calendar year in which
15 such individual’s taxable year begins.”.

16 (b) HSAs.—

17 (1) IN GENERAL.—Subparagraph (A) of section
18 223(e)(8) of such Code, as amended by this Act, is
19 amended—

20 (A) by inserting “or adult child” after
21 “surviving spouse”,

22 (B) by inserting “or adult child, as the
23 case may be,” after “the spouse”, and

24 (C) by inserting “or adult child” after
25 “spouse” in the heading thereof.

1 (2) ADULT CHILD DEFINED.—Paragraph (8) of
 2 section 223(e) of such Code, as amended by this
 3 Act, is amended by adding at the end the following
 4 new subparagraph:

5 “(C) ADULT CHILD.—For purposes of this
 6 paragraph, the term ‘adult child’ has the mean-
 7 ing given such term by section 220(f)(8)(C).”.

8 (c) EFFECTIVE DATE.—The amendments made by
 9 this section shall apply to taxable years beginning after
 10 December 31, 2013.

11 **SEC. 111. DISPOSITION OF UNUSED HEALTH BENEFITS IN**
 12 **CAFETERIA PLANS AND FLEXIBLE SPENDING**
 13 **ARRANGEMENTS.**

14 (a) IN GENERAL.—Section 125 of the Internal Rev-
 15 enue Code of 1986 is amended by redesignating sub-
 16 sections (k) and (l) as subsections (l) and (m), respec-
 17 tively, and by inserting after subsection (j) the following:

18 “(k) CARRYFORWARDS OR PAYMENTS OF CERTAIN
 19 UNUSED HEALTH BENEFITS.—

20 “(1) IN GENERAL.—For purposes of this title,
 21 a plan or other arrangement shall not fail to be
 22 treated as a cafeteria plan solely because qualified
 23 benefits under such plan include a health flexible
 24 spending arrangement under which not more than
 25 \$500 of unused health benefits may be—

1 “(A) carried forward to the succeeding
2 plan year of such health flexible spending ar-
3 rangement, or

4 “(B) paid to or on behalf of an employee
5 as compensation as of the end of such plan year
6 or upon the termination of, or failure to re-en-
7 roll in, such plan or arrangement.

8 “(2) DISTRIBUTION OF UNUSED HEALTH BENE-
9 FITS ON BEHALF OF EMPLOYEE.—For purposes of
10 paragraph (1)(B), unused health benefits paid as
11 compensation on behalf of an employee by the em-
12 ployer shall be—

13 “(A) includible in gross income and wages
14 of the employee, whether or not a deduction for
15 such payment is allowable under this title to the
16 employee, and

17 “(B) excludable from—

18 “(i) gross income to the extent pro-
19 vided under section 402(e), 457(a) (with
20 respect to contributions to an eligible de-
21 ferred compensation plan (as defined in
22 section 457(b)) of an eligible employer de-
23 scribed in section 457(e)(1)(A)), or 220,
24 and

1 “(ii) wages to the extent otherwise
2 provided for amounts so excludable.

3 “(3) UNUSED HEALTH BENEFITS.—For pur-
4 poses of this subsection, the term ‘unused health
5 benefits’ means the excess of—

6 “(A) the maximum amount of reimburse-
7 ment allowable during a plan year under a
8 health flexible spending arrangement, over

9 “(B) the actual amount of reimbursement
10 during such year under such arrangement.”.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall apply to taxable years beginning after
13 December 31, 2013.

14 **SEC. 112. PERMITTING BENEFICIARY CONTRIBUTIONS TO**
15 **MEDICARE ADVANTAGE MSA.**

16 (a) IN GENERAL.—Subsection (b) of section 138 of
17 such Code is amended by striking paragraph (2) and by
18 redesignating paragraphs (3) and (4) as paragraphs (2)
19 and (3), respectively.

20 (b) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 2013.

1 **SEC. 113. CHILD HEALTH SAVINGS ACCOUNT.**

2 (a) IN GENERAL.—Section 223 of the Internal Rev-
3 enue Code of 1986, as amended by this Act, is amended
4 by adding at the end the following new subsection:

5 “(h) CHILD HEALTH SAVINGS ACCOUNTS.—

6 “(1) IN GENERAL.—In the case of an indi-
7 vidual, in addition to any deduction allowed under
8 subsection (a) for any taxable year, there shall be al-
9 lowed as a deduction under this section an amount
10 equal to the aggregate amount paid in cash by the
11 taxpayer during the taxable year to a child health
12 savings account of a child of the taxpayer.

13 “(2) LIMITATION.—The amount taken into ac-
14 count under paragraph (1) with respect to each child
15 of the taxpayer for the taxable year shall not exceed
16 an amount equal to \$3,000.

17 “(3) CHILD HEALTH SAVINGS ACCOUNT.—For
18 purposes of this subsection, the term ‘child health
19 savings account’ means a health savings account
20 designated as a child health savings account and es-
21 tablished for the benefit of a child of a taxpayer, but
22 only if—

23 “(A) such account was established for the
24 benefit of the child before the child attains the
25 age of 5, and

1 “(B) under the written governing instru-
2 ment creating the trust, no contribution will be
3 accepted to the extent such contribution, when
4 added to previous contributions to the trust for
5 the calendar year, exceeds the dollar amount in
6 effect under paragraph (2).

7 “(4) TREATMENT OF ACCOUNT BEFORE AGE
8 18.—For purposes of this section, except as other-
9 wise provided in this subsection, a child health sav-
10 ings account established for the benefit of the child
11 of a taxpayer shall be treated as a health savings ac-
12 count of the taxpayer until the child attains the age
13 of 18, after which such account shall be treated as
14 a health savings account of the child.

15 “(5) DISTRIBUTIONS.—

16 “(A) IN GENERAL.—In the case of a child
17 health savings account established under this
18 section for the benefit of a child of a tax-
19 payer—

20 “(i) BEFORE AGE 18.—Any amount
21 paid or distributed out of such account be-
22 fore the child has attained the age of 18,
23 shall be included in the gross income of the
24 taxpayer, and subparagraph (A) of sub-
25 section (f) shall apply (relating to addi-

1 tional tax on distributions not used for
2 qualified medical expenses).

3 “(ii) AGE 18 AND OLDER.—Any
4 amount paid or distributed out of such ac-
5 count after the child has attained the age
6 of 18 may only be treated as used to pay
7 qualified medical expenses to the extent
8 such child is not covered as a dependent
9 under insurance (other than permitted in-
10 surance) of a parent.

11 “(B) EXCEPTIONS FOR DISABILITY OR
12 DEATH OF CHILD.—If the child becomes dis-
13 abled within the meaning of section 72(m)(7) or
14 dies—

15 “(i) subparagraph (A) shall not apply
16 to any subsequent payment or distribution,
17 and

18 “(ii) the taxpayer may rollover the
19 amount in such account to an individual
20 retirement plan of the taxpayer, to any
21 health savings account of the taxpayer, or
22 to any child health savings account of any
23 other child of the taxpayer.

24 “(C) HEALTH INSURANCE MAY BE PUR-
25 CHASED FROM ACCOUNT.—Subparagraph (B)

1 of subsection (d)(2) shall not apply to any
 2 health savings account originally established as
 3 a child health savings account.

4 “(6) REGULATIONS.—The Secretary shall pre-
 5 scribe such regulations as may be necessary to carry
 6 out the purposes of this subsection, including rules
 7 for determining application of this subsection in the
 8 case of legal guardians and in the case of parents
 9 of a child who file separately, are separated, or are
 10 not married.”.

11 (b) EFFECTIVE DATE.—The amendments made by
 12 this section shall apply to taxable years beginning after
 13 December 31, 2013.

14 **TITLE II—HEALTH INSURANCE** 15 **PROVISIONS**

16 **SEC. 201. COOPERATIVE GOVERNING OF INDIVIDUAL AND** 17 **GROUP HEALTH INSURANCE COVERAGE.**

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

21 **“PART D—COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE** 22 **COVERAGE**

24 **“SEC. 2795. DEFINITIONS.**

25 “In this part:

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

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

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

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

12 “(5) GROUP HEALTH INSURANCE COVERAGE.—
13 The term ‘group health insurance coverage’ has the
14 meaning given such term in 2791(b)(4).

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

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

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

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

6 “(8) COVERED LAWS.—

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

11 “(i) individual or group health insur-
12 ance coverage issued by a health insurance
13 issuer;

14 “(ii) the offer, sale, rating (including
15 medical underwriting), renewal, and
16 issuance of individual or group health in-
17 surance coverage to an individual;

18 “(iii) the provision to an individual in
19 relation to individual or group health in-
20 surance coverage of health care and insur-
21 ance related services;

22 “(iv) the provision to an individual in
23 relation to individual or group health in-
24 surance coverage of management, oper-

1 ations, and investment activities of a
2 health insurance issuer; and

3 “(v) the provision to an individual in
4 relation to individual or group health in-
5 surance coverage of loss control and claims
6 administration for a health insurance
7 issuer with respect to liability for which
8 the issuer provides insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ondary State and only if the covered laws of the primary
2 State—

3 “(1) do not apply any age limitations with re-
4 spect to who may purchase such coverage that is a
5 high deductible health plan; and

6 “(2) do not require such coverage that is a high
7 deductible health plan to provide for any specific
8 type of coverage.

9 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
10 ONDARY STATE.—Except as provided in this section, a
11 health insurance issuer with respect to its offer, sale, rat-
12 ing (including medical underwriting), renewal, and
13 issuance of individual or group health insurance coverage
14 in any secondary State is exempt from any covered laws
15 of the secondary State (and any rules, regulations, agree-
16 ments, or orders sought or issued by such State under or
17 related to such covered laws) to the extent that such laws
18 would—

19 “(1) make unlawful, or regulate, directly or in-
20 directly, the operation of the health insurance issuer
21 operating in the secondary State, except that any
22 secondary State may require such an issuer—

23 “(A) to pay, on a nondiscriminatory basis,
24 applicable premium and other taxes (including
25 high risk pool assessments) which are levied on

1 insurers and surplus lines insurers, brokers, or
2 policyholders under the laws of the State;

3 “(B) to register with and designate the
4 State insurance commissioner as its agent solely
5 for the purpose of receiving service of legal doc-
6 uments or process;

7 “(C) to submit to an examination of its fi-
8 nancial condition by the State insurance com-
9 missioner in any State in which the issuer is
10 doing business to determine the issuer’s finan-
11 cial condition, if—

12 “(i) the State insurance commissioner
13 of the primary State has not done an ex-
14 amination within the period recommended
15 by the National Association of Insurance
16 Commissioners; and

17 “(ii) any such examination is con-
18 ducted in accordance with the examiners’
19 handbook of the National Association of
20 Insurance Commissioners and is coordi-
21 nated to avoid unjustified duplication and
22 unjustified repetition;

23 “(D) to comply with a lawful order
24 issued—

1 “(i) in a delinquency proceeding com-
2 menced by the State insurance commis-
3 sioner if there has been a finding of finan-
4 cial impairment under subparagraph (C);
5 or

6 “(ii) in a voluntary dissolution pro-
7 ceeding;

8 “(E) to comply with an injunction issued
9 by a court of competent jurisdiction, upon a pe-
10 tition by the State insurance commissioner al-
11 leging that the issuer is in hazardous financial
12 condition;

13 “(F) to participate, on a nondiscriminatory
14 basis, in any insurance insolvency guaranty as-
15 sociation or similar association to which a
16 health insurance issuer in the State is required
17 to belong;

18 “(G) to comply with any State law regard-
19 ing fraud and abuse (as defined in section
20 2795(10)), except that if the State seeks an in-
21 junction regarding the conduct described in this
22 subparagraph, such injunction must be obtained
23 from a court of competent jurisdiction;

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

4 “(I) to comply with the applicable require-
5 ments for independent review under section
6 2798 with respect to coverage offered in the
7 State;

8 “(2) require any individual or group health in-
9 surance coverage issued by the issuer to be counter-
10 signed by an insurance agent or broker residing in
11 that secondary State;

12 “(3) apply any age limitations with respect to
13 who may purchase such coverage that is a high de-
14 ductible health plan;

15 “(4) require such coverage that is a high de-
16 ductible health plan to provide for any specific type
17 of coverage; or

18 “(5) otherwise discriminate against the issuer
19 issuing insurance in both the primary State and in
20 any secondary State.

21 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
22 health insurance issuer shall provide the following notice,
23 in 12-point bold type, in any insurance coverage offered
24 in a secondary State under this part by such a health in-
25 surance issuer and at renewal of the policy, with the 5

1 blank spaces therein being appropriately filled with the
 2 name of the health insurance issuer, the name of primary
 3 State, the name of the secondary State, the name of the
 4 secondary State, and the name of the secondary State, re-
 5 spectively, for the coverage concerned: ‘Notice: This policy
 6 is issued by _____ and is governed by the laws and
 7 regulations of the State of _____, and it has met all
 8 the laws of that State as determined by that State’s De-
 9 partment of Insurance. This policy may be less expensive
 10 than others because it is not subject to all of the insurance
 11 laws and regulations of the State of _____, includ-
 12 ing coverage of some services or benefits mandated by the
 13 law of the State of _____. Additionally, this policy
 14 is not subject to all of the consumer protection laws or
 15 restrictions on rate changes of the State of _____.
 16 As with all insurance products, before purchasing this pol-
 17 icy, you should carefully review the policy and determine
 18 what health care services the policy covers and what bene-
 19 fits it provides, including any exclusions, limitations, or
 20 conditions for such services or benefits.’.

21 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
 22 AND PREMIUM INCREASES.—

23 “(1) IN GENERAL.—For purposes of this sec-
 24 tion, a health insurance issuer that provides indi-
 25 vidual or group health insurance coverage to an indi-

1 vidual under this part in a primary or secondary
2 State may not upon renewal—

3 “(A) move or reclassify the individual in-
4 sured under the health insurance coverage from
5 the class such individual is in at the time of
6 issue of the contract based on the health status-
7 related factors of the individual; or

8 “(B) increase the premiums assessed the
9 individual for such coverage based on a health
10 status-related factor or change of a health sta-
11 tus-related factor or the past or prospective
12 claim experience of the insured individual.

13 “(2) CONSTRUCTION.—Nothing in paragraph
14 (1) shall be construed to prohibit a health insurance
15 issuer—

16 “(A) from terminating or discontinuing
17 coverage or a class of coverage in accordance
18 with subsections (b) and (c) of section 2742;

19 “(B) from raising premium rates for all
20 policyholders within a class based on claims ex-
21 perience;

22 “(C) from changing premiums or offering
23 discounted premiums to individuals who engage
24 in wellness activities at intervals prescribed by

1 the issuer, if such premium changes or incen-
 2 tives—

3 “(i) are disclosed to the consumer in
 4 the insurance contract;

5 “(ii) are based on specific wellness ac-
 6 tivities that are not applicable to all indi-
 7 viduals; and

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

10 “(D) from reinstating lapsed coverage; or

11 “(E) from retroactively adjusting the rates
 12 charged an insured individual if the initial rates
 13 were set based on material misrepresentation by
 14 the individual at the time of issue.

15 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
 16 STATE.—A health insurance issuer may not offer for sale
 17 individual or group health insurance coverage in a sec-
 18 ondary State unless that coverage is currently offered for
 19 sale in the primary State.

20 “(f) LICENSING OF AGENTS OR BROKERS FOR
 21 HEALTH INSURANCE ISSUERS.—Any State may require
 22 that a person acting, or offering to act, as an agent or
 23 broker for a health insurance issuer with respect to the
 24 offering of individual or group health insurance coverage
 25 obtain a license from that State, with commissions or

1 other compensation subject to the provisions of the laws
2 of that State, except that a State may not impose any
3 qualification or requirement which discriminates against
4 a nonresident agent or broker.

5 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
6 SURANCE COMMISSIONER.—Each health insurance issuer
7 issuing individual or group health insurance coverage in
8 both primary and secondary States shall submit—

9 “(1) to the insurance commissioner of each
10 State in which it intends to offer such coverage, be-
11 fore it may offer individual or group health insur-
12 ance coverage in such State—

13 “(A) a copy of the plan of operation or fea-
14 sibility study or any similar statement of the
15 policy being offered and its coverage (which
16 shall include the name of its primary State and
17 its principal place of business);

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

20 “(C) written notice from the issuer of the
21 issuer’s compliance with all the laws of the pri-
22 mary State; and

23 “(2) to the insurance commissioner of each sec-
24 ondary State in which it offers individual or group
25 health insurance coverage, a copy of the issuer’s

1 quarterly financial statement submitted to the pri-
2 mary State, which statement shall be certified by an
3 independent public accountant and contain a state-
4 ment of opinion on loss and loss adjustment expense
5 reserves made by—

6 “(A) a member of the American Academy
7 of Actuaries; or

8 “(B) a qualified loss reserve specialist.

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

12 “(1) the solicitation or sale of individual or
13 group health insurance coverage by a health insur-
14 ance issuer to any person or group who is not eligi-
15 ble for such insurance; or

16 “(2) the solicitation or sale of individual or
17 group health insurance coverage that violates the re-
18 quirements of the law of a secondary State which
19 are described in subparagraphs (A) through (H) of
20 section 2796(b)(1).

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

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

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

9 “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

17 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
18 this section shall be construed to affect the applicability
19 of State laws generally applicable to persons or corpora-
20 tions.

21 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
22 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
23 health insurance issuer is offering coverage in a primary
24 State that does not accommodate residents of secondary
25 States or does not provide a working mechanism for resi-

1 dents of a secondary State, and the issuer is offering cov-
2 erage under this part in such secondary State which has
3 not adopted a qualified high risk pool as its acceptable
4 alternative mechanism (as defined in section 2744(c)(2)),
5 the issuer shall, with respect to any individual or group
6 health insurance coverage offered in a secondary State
7 under this part, comply with the guaranteed availability
8 requirements for eligible individuals in section 2741.

9 “(n) NO MANDATED BENEFIT COVERAGE REQUIRE-
10 MENTS.—Notwithstanding any other provision of law, a
11 health insurance issuer offering individual or group health
12 insurance coverage in a primary State and in any sec-
13 ondary State in accordance with this part (and any cov-
14 erage so offered) shall not be subject to any Federal law
15 that would otherwise—

16 “(1) apply any age limitations with respect to
17 who may purchase such coverage that is a high de-
18 ductible health plan; or

19 “(2) require such coverage that is a high de-
20 ductible health plan to provide for any specific type
21 of coverage.

1 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
2 **BEFORE ISSUER MAY SELL INTO SECONDARY**
3 **STATES.**

4 “A health insurance issuer may not offer, sell, or
5 issue individual or group health insurance coverage in a
6 secondary State if the State insurance commissioner does
7 not use a risk-based capital formula for the determination
8 of capital and surplus requirements for all health insur-
9 ance issuers.

10 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
11 **DURES.**

12 “(a) RIGHT TO EXTERNAL APPEAL.—A health insur-
13 ance issuer may not offer, sell, or issue individual or group
14 health insurance coverage in a secondary State under the
15 provisions of this title unless—

16 “(1) both the secondary State and the primary
17 State have legislation or regulations in place estab-
18 lishing an independent review process for individuals
19 who are covered by individual health insurance cov-
20 erage or group health insurance offered by a health
21 insurance issuer, respectively, or

22 “(2) in any case in which the requirements of
23 subparagraph (A) are not met with respect to the ei-
24 ther of such States, the issuer provides an inde-
25 pendent review mechanism substantially identical (as
26 determined by the applicable State authority of such

1 State) to that prescribed in the ‘Health Carrier Ex-
2 ternal Review Model Act’ of the National Association
3 of Insurance Commissioners for all individuals who
4 purchase insurance coverage under the terms of this
5 part, except that, under such mechanism, the review
6 is conducted by an independent medical reviewer, or
7 a panel of such reviewers, with respect to whom the
8 requirements of subsection (b) are met.

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

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

16 “(A) each independent medical reviewer
17 meets the qualifications described in paragraphs
18 (2) and (3);

19 “(B) with respect to each review, each re-
20 viewer meets the requirements of paragraph (4)
21 and the reviewer, or at least 1 reviewer on the
22 panel, meets the requirements described in
23 paragraph (5); and

1 “(C) compensation provided by the issuer
2 to each reviewer is consistent with paragraph
3 (6).

4 “(2) LICENSURE AND EXPERTISE.—Each inde-
5 pendent medical reviewer shall be a physician
6 (allopathic or osteopathic) or health care profes-
7 sional who—

8 “(A) is appropriately credentialed or li-
9 censed in 1 or more States to deliver health
10 care services; and

11 “(B) typically treats the condition, makes
12 the diagnosis, or provides the type of treatment
13 under review.

14 “(3) INDEPENDENCE.—

15 “(A) IN GENERAL.—Subject to subpara-
16 graph (B), each independent medical reviewer
17 in a case shall—

18 “(i) not be a related party (as defined
19 in paragraph (7));

20 “(ii) not have a material familial, fi-
21 nancial, or professional relationship with
22 such a party; and

23 “(iii) not otherwise have a conflict of
24 interest with such a party (as determined
25 under regulations).

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

3 “(i) prohibit an individual, solely on
4 the basis of affiliation with the issuer,
5 from serving as an independent medical re-
6 viewer if—

7 “(I) a non-affiliated individual is
8 not reasonably available;

9 “(II) the affiliated individual is
10 not involved in the provision of items
11 or services in the case under review;

12 “(III) the fact of such an affili-
13 ation is disclosed to the issuer and the
14 enrollee (or authorized representative)
15 and neither party objects; and

16 “(IV) the affiliated individual is
17 not an employee of the issuer and
18 does not provide services exclusively or
19 primarily to or on behalf of the issuer;

20 “(ii) prohibit an individual who has
21 staff privileges at the institution where the
22 treatment involved takes place from serv-
23 ing as an independent medical reviewer
24 merely on the basis of such affiliation if
25 the affiliation is disclosed to the issuer and

1 the enrollee (or authorized representative),
2 and neither party objects; or

3 “(iii) prohibit receipt of compensation
4 by an independent medical reviewer from
5 an entity if the compensation is provided
6 consistent with paragraph (6).

7 “(4) PRACTICING HEALTH CARE PROFESSIONAL
8 IN SAME FIELD.—

9 “(A) IN GENERAL.—In a case involving
10 treatment, or the provision of items or serv-
11 ices—

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

21 “(ii) by a non-physician health care
22 professional, the reviewer, or at least 1
23 member of the review panel, shall be a
24 practicing non-physician health care pro-
25 fessional of the same or similar specialty

1 as the non-physician health care profes-
2 sional who, acting within the appropriate
3 scope of practice within the State in which
4 the service is provided or rendered, typi-
5 cally treats the condition, makes the diag-
6 nosis, or provides the type of treatment
7 under review.

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

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

18 “(6) LIMITATIONS ON REVIEWER COMPENSA-
19 TION.—Compensation provided by the issuer to an
20 independent medical reviewer in connection with a
21 review under this section shall—

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

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

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

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

7 “(B) The enrollee (or authorized represent-
8 ative).

9 “(C) The health care professional that pro-
10 vides the items or services involved in the de-
11 nial.

12 “(D) The institution at which the items or
13 services (or treatment) involved in the denial
14 are provided.

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

18 “(F) Any other party determined under
19 any regulations to have a substantial interest in
20 the denial involved.

21 “(8) DEFINITIONS.—For purposes of this sub-
22 section:

23 “(A) ENROLLEE.—The term ‘enrollee’
24 means, with respect to health insurance cov-
25 erage offered by a health insurance issuer, an

1 individual enrolled with the issuer to receive
2 such coverage.

3 “(B) HEALTH CARE PROFESSIONAL.—The
4 term ‘health care professional’ means an indi-
5 vidual who is licensed, accredited, or certified
6 under State law to provide specified health care
7 services and who is operating within the scope
8 of such licensure, accreditation, or certification.

9 **“SEC. 2799. ENFORCEMENT.**

10 “(a) IN GENERAL.—Subject to subsection (b), with
11 respect to specific individual or group health insurance
12 coverage the primary State for such coverage has sole ju-
13 risdiction to enforce the primary State’s covered laws in
14 the primary State and any secondary State.

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

19 “(c) COURT INTERPRETATION.—In reviewing action
20 initiated by the applicable secondary State authority, the
21 court of competent jurisdiction shall apply the covered
22 laws of the primary State.

23 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
24 of individual health insurance coverage offered in a sec-
25 ondary State, or group health insurance coverage offered

1 by a health insurance issuer in a secondary State, that
2 fails to comply with the covered laws of the primary State,
3 the applicable State authority of the secondary State may
4 notify the applicable State authority of the primary
5 State.”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall apply to health insurance coverage of-
8 fered, issued, or sold after the date that is one year after
9 the date of the enactment of this Act.

10 (c) GAO ONGOING STUDY AND REPORTS.—

11 (1) STUDY.—The Comptroller General of the
12 United States shall conduct an ongoing study con-
13 cerning the effect of the amendment made by sub-
14 section (a) on—

15 (A) the number of uninsured and under-in-
16 sured;

17 (B) the availability and cost of health in-
18 surance policies for individuals with pre-existing
19 medical conditions;

20 (C) the availability and cost of health in-
21 surance policies generally;

22 (D) the elimination or reduction of dif-
23 ferent types of benefits under health insurance
24 policies offered in different States; and

1 (E) cases of fraud or abuse relating to
 2 health insurance coverage offered under such
 3 amendment and the resolution of such cases.

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

9 **SEC. 202. REAUTHORIZATION OF THE PREEXISTING CONDI-**
 10 **TION INSURANCE PLAN (PCIP) PROGRAM.**

11 (a) IN GENERAL.—The PCIP program is hereby re-
 12 authorized through December 31, 2016, and shall con-
 13 tinue in effect subject to the provisions of this section.

14 (b) ELIMINATION OF REQUIREMENT FOR NONCOV-
 15 ERAGE FOR 6 MONTHS TO BE ELIGIBLE INDIVIDUAL.—
 16 The condition under paragraph (2) of section 1101(d) of
 17 the Patient Protection and Affordable Care Act (42
 18 U.S.C. 18001(d)) shall not apply to the reauthorized
 19 PCIP program.

20 (c) FUNDING.—

21 (1) INITIAL FUNDING.—Initial funding for the
 22 reauthorized PCIP program shall be derived from
 23 the following:

24 (A) Funding that was available in the Pa-
 25 tient-Centered Outcomes Research Institute

1 Trust Fund under section 9511 of the Internal
2 Revenue Code of 1986 on the day before the
3 date of the enactment of this Act.

4 (B) Any unobligated funds in the Preven-
5 tion and Public Health Fund (under section
6 4002 of Public Law 111–148, 42 U.S.C. 300u–
7 11) attributable to fiscal year 2013 as of the
8 day before the date of the enactment of this
9 Act.

10 (2) SUBSEQUENT FUNDING.—Subsequent fund-
11 ing for the reauthorized PCIP program shall be de-
12 rived from any funds that would otherwise be made
13 available to such Prevention and Public Health
14 Fund for fiscal years 2014 through 2016.

15 (3) TRANSFER.—Funding under the previous
16 paragraphs shall be transferred to an account within
17 the Department of Health and Human Services that
18 provided funding, as of the day before the date of
19 the enactment of this Act, to carry out the PCIP
20 program.

21 (d) DEFINITIONS.—In this section:

22 (1) The term “PCIP program” means the Pre-
23 existing Condition Insurance Plan (PCIP) Program
24 established as of the day before the date of the en-

1 actment of this Act under section 1101 of Public
2 Law 111–148 (42 U.S.C. 18001).

3 (2) The term “reauthorized PCIP program”
4 means the PCIP program as reauthorized under this
5 section.

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