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(Original Signature of Member)

111TH CONGRESS  
1ST SESSION

**H. R.** \_\_\_\_\_

To amend the Internal Revenue Code of 1986 to repeal the percentage floor on medical expense deductions, expand the use of tax-preferred health care accounts, and establish a charity care credit, to amend the Social Security Act to create a Medicare voucher program and reform EMTALA requirements, and to amend Public Health Service Act to provide for cooperative governing of individual health insurance coverage offered in interstate commerce.

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**IN THE HOUSE OF REPRESENTATIVES**

Mr. BROUN of Georgia introduced the following bill; which was referred to the Committee on \_\_\_\_\_

\_\_\_\_\_  
**A BILL**

To amend the Internal Revenue Code of 1986 to repeal the percentage floor on medical expense deductions, expand the use of tax-preferred health care accounts, and establish a charity care credit, to amend the Social Security Act to create a Medicare voucher program and reform EMTALA requirements, and to amend Public Health Service Act to provide for cooperative governing of individual health insurance coverage offered in interstate commerce.

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; CON-**  
 4       **STRUCTION.**

5       (a) SHORT TITLE.—This Act may be cited as the  
 6       “Offering Patients True Individualized Options Act of  
 7       2009” or the “OPTION Act of 2009”.

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

Sec. 1. Short title; table of contents; construction.

TITLE I—HEALTH CARE TAX REFORM

- Sec. 101. Elimination of 7.5-percent floor on medical expense deductions.
- Sec. 102. Repeal of prescribed drug limitation on deduction for medical care.
- Sec. 103. Repeal of 2-percent miscellaneous itemized deduction floor for medical expense deductions.
- Sec. 104. Healthcare savings account reform.
- Sec. 105. Charity care credit.
- Sec. 106. COBRA continuation coverage extended.
- Sec. 107. HSA charitable contributions.

TITLE II—MEDICARE VOUCHER PROGRAM

- Sec. 201. Replacement of Medicare part A entitlement with Medicare Reform Voucher Program.

TITLE III—EMTALA REFORMS

- Sec. 301. EMTALA reforms.

TITLE IV—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH  
INSURANCE COVERAGE

- Sec. 401. Cooperative governing of individual health insurance coverage.

TITLE V—ASSOCIATION HEALTH PLANS

- Sec. 501. Short title.
- Sec. 502. Rules governing association health plans.
- Sec. 503. Clarification of treatment of single employer arrangements.
- Sec. 504. Enforcement provisions relating to association health plans.
- Sec. 505. Cooperation between Federal and State authorities.
- Sec. 506. Effective date and transitional and other rules.

1 (c) CONSTRUCTION.—Nothing in this Act shall be  
2 construed to preclude or prohibit a health care provider  
3 or health insurance issuer from publicly disclosing any  
4 pricing of services provided or covered.

5 **TITLE I—HEALTH CARE TAX**  
6 **REFORM**

7 **SEC. 101. ELIMINATION OF 7.5-PERCENT FLOOR ON MED-**  
8 **ICAL EXPENSE DEDUCTIONS.**

9 (a) IN GENERAL.—Subsection (a) of section 213 of  
10 the Internal Revenue Code of 1986 is amended by striking  
11 “, to the extent that such expenses exceed 7.5 percent of  
12 adjusted gross income”.

13 (b) CONFORMING AMENDMENT.—Paragraph (1) of  
14 section 56(b) of such Code is amended by striking sub-  
15 paragraph (B).

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to taxable years beginning after  
18 December 31, 2009.

19 **SEC. 102. REPEAL OF PRESCRIBED DRUG LIMITATION ON**  
20 **DEDUCTION FOR MEDICAL CARE.**

21 (a) IN GENERAL.—Section 213 of the Internal Rev-  
22 enue Code of 1986 is amended by striking subsection (b).

23 (b) CONFORMING AMENDMENT.—Subsection (d) of  
24 section 213 of such Code is amended by striking para-  
25 graph (3).

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2009.

4 **SEC. 103. REPEAL OF 2-PERCENT MISCELLANEOUS**  
5 **ITEMIZED DEDUCTION FLOOR FOR MEDICAL**  
6 **EXPENSE DEDUCTIONS.**

7 (a) IN GENERAL.—Subsection (b) of section 67 of the  
8 Internal Revenue Code of 1986 is amended by striking  
9 paragraph (5).

10 (b) EFFECTIVE DATE.—The amendment made by  
11 this section shall apply to taxable years beginning after  
12 the December 31, 2009.

13 **SEC. 104. HEALTHCARE SAVINGS ACCOUNT REFORM.**

14 (a) INCREASE IN DEDUCTIBLE CONTRIBUTION LIM-  
15 ITATIONS.—

16 (1) IN GENERAL.—Paragraph (2) of section  
17 223(b) of the Internal Revenue Code of 1986 is  
18 amended—

19 (A) in subparagraph (A) by striking  
20 “\$2,250” and inserting “the amount in effect  
21 for such month under subsection  
22 (c)(2)(A)(ii)(I)”, and

23 (B) in subparagraph (B) by striking  
24 “\$4,500” and inserting “the amount in effect

1           for     such     month     under     subsection  
2           (c)(2)(A)(ii)(II)”.

3           (2) CONFORMING AMENDMENT.—Paragraph (1)  
4     of section 223(g) is amended by striking “sub-  
5     sections (b)(2) and” and inserting “subsection”.

6           (b) MEDICARE ELIGIBLE INDIVIDUALS ELIGIBLE TO  
7     CONTRIBUTE TO HSA.—

8           (1) Subsection (b) of section 223 of such Code  
9     is amended by striking paragraph (7).

10          (2) Paragraph (1) of section 223(c) of such  
11     Code is amended by adding at the end the following  
12     new subparagraph:

13                 “(C) SPECIAL RULE FOR INDIVIDUALS EN-  
14                 TITLED TO BENEFITS UNDER MEDICARE.—In  
15                 the case of an individual—

16                         “(i) who is entitled to benefits under  
17                         title XVIII of the Social Security Act, and

18                         “(ii) with respect to whom a health  
19                         savings account is established in a month  
20                         before the first month such individual is  
21                         entitled to such benefits,  
22                         such individual shall be deemed to be an eligible  
23                         individual.”.

24           (c) ROLLOVER TO MEDICARE ADVANTAGE MSA.—

1           (1) IN GENERAL.—Paragraph (2) of section  
2       138(b) of such Code is amended by striking “or” at  
3       the end of subparagraph (A), by adding “or” at the  
4       end of subparagraph (C), and by adding at the end  
5       the following new subparagraph:

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

8           (2) HSA ROLLOVER CONTRIBUTION.—Sub-  
9       section (c) of section 138 of such Code is amended  
10      by adding at the end the following new paragraph:

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

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

23                   “(B) LIMITATION.—This paragraph shall  
24      not apply to any amount described in subpara-  
25      graph (A) received by an individual from a

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

8 (3) CONFORMING AMENDMENT.—Subparagraph  
9 (A) of section 223(f)(5) of such Code is amended by  
10 inserting “or Medicare Advantage MSA” after “into  
11 a health savings account”.

12 (d) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to taxable years beginning after  
14 December 31, 2009.

15 **SEC. 105. CHARITY CARE CREDIT.**

16 (a) IN GENERAL.—Subpart A of part IV of sub-  
17 chapter A of chapter 1 of the Internal Revenue Code of  
18 1986 (relating to nonrefundable personal credits) is  
19 amended by inserting after section 25D the following new  
20 section:

21 **“SEC. 25E. CHARITY CARE CREDIT.**

22 “(a) ALLOWANCE OF CREDIT.—In the case of a phy-  
23 sician, there shall be allowed as a credit against the tax  
24 imposed by this chapter for a taxable year the amount  
25 determined in accordance with the following table:

**“If the physician has provided during such taxable year:      The amount of the credit is:**

At least 25 but less than 30 qualified hours of charity care.	\$2,000.
At least 30 but less than 35 qualified hours of charity care.	\$2,400.
At least 35 but less than 40 qualified hours of charity care.	\$2,800.
At least 40 but less than 45 qualified hours of charity care.	\$3,200.
At least 45 but less than 50 qualified hours of charity care.	\$3,600.
At least 50 but less than 55 qualified hours of charity care.	\$4,000.
At least 55 but less than 60 qualified hours of charity care.	\$4,400.
At least 60 but less than 65 qualified hours of charity care.	\$4,800.
At least 65 but less than 70 qualified hours of charity care.	\$5,200.
At least 70 but less than 75 qualified hours of charity care.	\$5,600.
At least 75 but less than 80 qualified hours of charity care.	\$6,000.
At least 80 but less than 85 qualified hours of charity care.	\$6,400.
At least 85 but less than 90 qualified hours of charity care.	\$6,800.
At least 90 but less than 95 qualified hours of charity care.	\$7,200.
At least 95 but less than 100 qualified hours of charity care.	\$7,600.
At least 100 hours of charity care .....	\$8,000.

1       “(b) QUALIFIED HOURS OF CHARITY CARE.—For  
2 purposes of this section—

3               “(1) QUALIFIED HOURS OF CHARITY CARE.—

4       The term ‘qualified hours of charity care’ means the  
5 hours that a physician provides medical care (as de-  
6 fined in section 213(d)(1)(A)) on a volunteer or pro  
7 bono basis.

8               “(2) PHYSICIAN.—The term ‘physician’ has the  
9 meaning given to such term in section 1861(r) of the  
10 Social Security Act (42 U.S.C. 1395x(r)).”.



1 (b) CONFORMING AMENDMENT.—The table of sec-  
2 tions for subpart A of part IV of subchapter A of chapter  
3 1 of such Code is amended by inserting after the item  
4 relating to section 25D the following new item:

“Sec. 25E. Charity care credit”.

5 (c) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to taxable years beginning after  
7 December 31, 2009.

8 **SEC. 106. COBRA CONTINUATION COVERAGE EXTENDED.**

9 (a) UNDER IRC.—Subparagraph (B) of section  
10 4980B(f)(2) of the Internal Revenue Code of 1986 is  
11 amended by striking clauses (i) and (v) and by redesignig-  
12 nating clauses (ii), (iii), and (iv) as clauses (i), (ii), and  
13 (iii), respectively.

14 (b) UNDER ERISA.—Paragraph (2) of section 602  
15 of the Employee Retirement Income Security Act of 2009  
16 (29 U.S.C. 1162) is amended by striking subparagraphs  
17 (A) and (E) and by redesignating subparagraphs (B), (C),  
18 and (D) as subparagraphs (A), (B), and (C), respectively.

19 (c) UNDER PHSA.—Paragraph (2) of section  
20 2202(2) of the Public Health Service Act (42 U.S.C.  
21 300bb-2(2)) is amended by striking subparagraphs (A)  
22 and (E) and by redesignating subparagraphs (B), (C), and  
23 (D) as subparagraphs (A), (B), and (C), respectively.

24 (d) EFFECTIVE DATE.—The amendments made by  
25 this section shall apply with respect to group health plans,

1 and health insurance coverage offered in connection with  
2 group health plans, for plan years beginning after the date  
3 of the enactment of this Act.

4 **SEC. 107. HSA CHARITABLE CONTRIBUTIONS.**

5 (a) IN GENERAL.—Subsection (f) of section 223 of  
6 the Internal Revenue Code of 1986 is amended by adding  
7 at the end the following new paragraph:

8 “(9) DISTRIBUTIONS FOR CHARITABLE PUR-  
9 POSES.—For purposes of this subsection—

10 “(A) IN GENERAL.—Paragraph (2) shall  
11 not apply to any qualified charitable distribu-  
12 tions with respect to a taxpayer made during  
13 any taxable year.

14 “(B) QUALIFIED CHARITABLE DISTRIBUTION.—For purposes of this paragraph, the  
15 term ‘qualified charitable distribution’ means  
16 any distribution from a health savings account  
17 which is made directly by the trustee to an or-  
18 ganization described in section 170(b)(1)(A)  
19 (other than any organization described in sec-  
20 tion 509(a)(3) or any fund or account described  
21 in section 4966(d)(2)). A distribution shall be  
22 treated as a qualified charitable distribution  
23 only to the extent that the distribution would be  
24

1 includible in gross income without regard to  
2 subparagraph (A).

3 “(C) CONTRIBUTIONS MUST BE OTHER-  
4 WISE DEDUCTIBLE.—For purposes of this para-  
5 graph, a distribution to an organization de-  
6 scribed in subparagraph (B) shall be treated as  
7 a qualified charitable distribution only if a de-  
8 duction for the entire distribution would be al-  
9 lowable under section 170 (determined without  
10 regard to subsection (b) thereof and this para-  
11 graph).

12 “(D) DENIAL OF DEDUCTION.—Qualified  
13 charitable distributions which are not includible  
14 in gross income pursuant to subparagraph (A)  
15 shall not be taken into account in determining  
16 the deduction under section 170.”.

17 (b) EFFECTIVE DATE.—The amendment made by  
18 this section shall apply to taxable years beginning after  
19 December 31, 2009.

1     **TITLE II—MEDICARE VOUCHER**  
2                     **PROGRAM**

3     **SEC. 201. REPLACEMENT OF MEDICARE PART A ENTITLE-**  
4                     **MENT WITH MEDICARE REFORM VOUCHER**  
5                     **PROGRAM.**

6             (a) IN GENERAL.—Section 226 of the Social Security  
7     Act (42 U.S.C. 426) is amended by adding at the end the  
8     following new subsections:

9             “(k) REPLACEMENT OF ENTITLEMENT WITH  
10     VOUCHER PROGRAM.—

11             “(1) IN GENERAL.—Notwithstanding the pre-  
12     vious provisions of this section, beginning the first  
13     January 1 after the date of the enactment of the Of-  
14     fering Patients True Individualized Options Act of  
15     2009, the Secretary shall establish a procedure  
16     under which an individual otherwise entitled under  
17     subsection (a) to benefits under part A of title  
18     XVIII shall in lieu of such entitlement be automati-  
19     cally enrolled in the Medicare Reform Voucher Pro-  
20     gram established under subsection (l).

21             “(2) TREATMENT UNDER THE INTERNAL REV-  
22     ENUE CODE OF 1986.—An individual who is enrolled  
23     under the Medicare Reform Voucher Program under  
24     paragraph (1) shall not be treated as entitled to ben-

1       efits under title XVIII for purposes of section  
2       223(b)(7) of the Internal Revenue Code of 1986.

3           “(3) INELIGIBILITY FOR PART B OR D BENE-  
4       FITS.—An individual shall not be eligible for benefits  
5       under part B or D of title XVIII once the individual  
6       is enrolled in the Medicare Reform Voucher Pro-  
7       gram under paragraph (1).

8       “(1) MEDICARE REFORM VOUCHER PROGRAM.—

9           “(1) ESTABLISHMENT OF PROGRAM.—The Sec-  
10      retary shall establish a program to be known as the  
11      Medicare Reform Voucher Program (in this sub-  
12      section referred to as the ‘voucher program’) con-  
13      sistent with this subsection.

14          “(2) AUTOMATIC ENROLLMENT.—An individual  
15      otherwise entitled under subsection (a) to benefits  
16      under part A of title XVIII shall be enrolled in the  
17      voucher program for the period during which such  
18      individual would otherwise be so entitled to benefits.

19          “(3) AMOUNT OF VOUCHER.—

20           “(A) IN GENERAL.—Subject to clause (ii),  
21      for each year that an individual is enrolled in  
22      the voucher program, the Secretary shall pro-  
23      vide a voucher to such individual in an amount  
24      determined by the Secretary that is based on  
25      the geographic location of the individual and

1 the cost of applicable health insurance coverage  
2 and benefits in such area.

3 “(B) COMPUTATION OF VOUCHER  
4 AMOUNTS.—The amount of a voucher provided  
5 to an individual located in a geographic area for  
6 a year shall be computed at 120 percent of the  
7 sum of the median premium and median de-  
8 ductible payment for such year for all health in-  
9 surance coverage offered by health insurance  
10 issuers in the individual market serving such  
11 area.

12 “(4) PERMISSIBLE USE OF VOUCHER.—A  
13 voucher under paragraph (3) may be used only for  
14 the following purposes:

15 “(A) For payment of premiums,  
16 deductibles, copayments, or other cost-sharing  
17 for enrollment of such individual for health in-  
18 surance coverage offered by health insurance  
19 issuers in the individual market.

20 “(B) As a contribution into a MSA plan  
21 established by such individual, as defined in  
22 section 138(b)(2) of the Internal Revenue Code  
23 of 1986.

24 “(5) MSA DEPOSITS.—Each voucher amount  
25 received by an individual under this subsection shall

1 be deposited, on behalf of such individual, into the  
2 MSA plan of such individual.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 this section shall take effect on the first January 1 after  
5 the date of the enactment of this Act and shall apply to  
6 an individual who becomes entitled to benefits under part  
7 A of title XVIII of the Social Security Act on or after  
8 such January 1.

### 9 **TITLE III—EMTALA REFORMS**

#### 10 **SEC. 301. EMTALA REFORMS.**

11 (a) USE OF QUALIFIED EMERGENCY DEPARTMENT  
12 PERSONNEL IN PERFORMING INITIAL SCREENING.—Sub-  
13 section (a) of section 1867 of the Social Security Act (42  
14 U.S.C. 1395dd) is amended—

15 (1) by designating the sentence beginning with  
16 “In the case of” as paragraph (1), with the heading  
17 “IN GENERAL.—” and appropriate indentation; and

18 (2) by adding at the end the following new  
19 paragraph:

20 “(2) PERMITTING APPLICATION OF ER  
21 TRIAGE.—

22 “(A) IN GENERAL.—The requirement of  
23 paragraph (1) that a hospital conduct an appro-  
24 priate medical screening examination of an indi-  
25 vidual is deemed to be satisfied if a qualified

1 emergency screener (as defined in subparagraph  
2 (B)) performs a preliminary triage-type screen-  
3 ing in which the personnel—

4 “(i) assesses the nature and extent of  
5 the individual’s illness or injury; and

6 “(ii) determines, based on such as-  
7 sessment, that an emergency medical con-  
8 dition does not exist.

9 “(B) QUALIFIED EMERGENCY SCREENER  
10 DEFINED.—In this paragraph, the term ‘quali-  
11 fied emergency screener’ means a physician, li-  
12 censed practical nurse or registered nurse,  
13 qualified emergency medical technician, or other  
14 individual with basic, health care education that  
15 meets standards specified by the Secretary as  
16 being sufficient to perform the screening de-  
17 scribed in subparagraph (A).”.

18 (b) REVISION OF EMERGENCY MEDICAL CONDITION  
19 DEFINITION.—Subsection (e)(1)(A) of such section is  
20 amended to read as follows:

21 “(A) a medical condition manifesting itself  
22 by symptoms of sufficient severity (including se-  
23 vere pain) and with an onset or of a course  
24 such that the absence of immediate medical at-  
25 tention could reasonably be expected to pose an



1 immediate risk to life or long-term health of the  
2 individual (or, with respect to a pregnant  
3 woman, the life or long-term health of the  
4 woman or her unborn child); or”.

5 (c) EFFECTIVE DATE.—The amendments made by  
6 this section shall take effect on the date of the enactment  
7 of this Act and shall apply to individuals who come to an  
8 emergency room on or after the date that is 30 days after  
9 the date of the enactment of this Act.

10 **TITLE IV—COOPERATIVE GOV-**  
11 **ERNING OF INDIVIDUAL**  
12 **HEALTH INSURANCE COV-**  
13 **ERAGE**

14 **SEC. 401. COOPERATIVE GOVERNING OF INDIVIDUAL**  
15 **HEALTH INSURANCE COVERAGE.**

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

19 **“PART D—COOPERATIVE GOVERNING OF**  
20 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

21 **“SEC. 2795. DEFINITIONS.**

22 “In this part:

23 “(1) PRIMARY STATE.—The term ‘primary  
24 State’ means, with respect to individual health insur-  
25 ance coverage offered by a health insurance issuer,

1 the State designated by the issuer as the State  
2 whose covered laws shall govern the health insurance  
3 issuer in the sale of such coverage under this part.

4 An issuer, with respect to a particular policy, may  
5 only designate one such State as its primary State  
6 with respect to all such coverage it offers. Such an  
7 issuer may not change the designated primary State  
8 with respect to individual health insurance coverage  
9 once the policy is issued, except that such a change  
10 may be made upon renewal of the policy. With re-  
11 spect to such designated State, the issuer is deemed  
12 to be doing business in that State.

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

21 “(3) HEALTH INSURANCE ISSUER.—The term  
22 ‘health insurance issuer’ has the meaning given such  
23 term in section 2791(b)(2), except that such an  
24 issuer must be licensed in the primary State and be

1 qualified to sell individual health insurance coverage  
2 in that State.

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

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

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

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

22 “(B) to pay other obligations in the normal  
23 course of business.

24 “(7) COVERED LAWS.—

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

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

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

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

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

20                  “(v) the provision to an individual in  
21                  relation to individual health insurance cov-  
22                  erage of loss control and claims adminis-  
23                  tration for a health insurance issuer with  
24                  respect to liability for which the issuer pro-  
25                  vides insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

1 by the National Association of Insurance  
2 Commissioners; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
24 AND PREMIUM INCREASES.—

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

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

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

16           “(2) CONSTRUCTION.—Nothing in paragraph  
17           (1) shall be construed to prohibit a health insurance  
18           issuer—

19                   “(A) from terminating or discontinuing  
20                   coverage or a class of coverage in accordance  
21                   with subsections (b) and (c) of section 2742;

22                   “(B) from raising premium rates for all  
23                   policy holders within a class based on claims ex-  
24                   perience;

1           “(C) from changing premiums or offering  
2           discounted premiums to individuals who engage  
3           in wellness activities at intervals prescribed by  
4           the issuer, if such premium changes or incen-  
5           tives—

6                   “(i) are disclosed to the consumer in  
7                   the insurance contract;

8                   “(ii) are based on specific wellness ac-  
9                   tivities that are not applicable to all indi-  
10                  viduals; and

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

13           “(D) from reinstating lapsed coverage; or

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

18       “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
19 STATE.—A health insurance issuer may not offer for sale  
20 individual health insurance coverage in a secondary State  
21 unless that coverage is currently offered for sale in the  
22 primary State.

23       “(f) LICENSING OF AGENTS OR BROKERS FOR  
24 HEALTH INSURANCE ISSUERS.—Any State may require  
25 that a person acting, or offering to act, as an agent or

1 broker for a health insurance issuer with respect to the  
2 offering of individual health insurance coverage obtain a  
3 license from that State, with commissions or other com-  
4 pensation subject to the provisions of the laws of that  
5 State, except that a State may not impose any qualifica-  
6 tion or requirement which discriminates against a non-  
7 resident agent or broker.

8 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
9 SURANCE COMMISSIONER.—Each health insurance issuer  
10 issuing individual health insurance coverage in both pri-  
11 mary and secondary States shall submit—

12 “(1) to the insurance commissioner of each  
13 State in which it intends to offer such coverage, be-  
14 fore it may offer individual health insurance cov-  
15 erage in such State—

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

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

23 “(C) written notice from the issuer of the  
24 issuer’s compliance with all the laws of the pri-  
25 mary State; and



1           “(2) to the insurance commissioner of each sec-  
2       ondary State in which it offers individual health in-  
3       surance coverage, a copy of the issuer’s quarterly fi-  
4       nancial statement submitted to the primary State,  
5       which statement shall be certified by an independent  
6       public accountant and contain a statement of opin-  
7       ion on loss and loss adjustment expense reserves  
8       made by—

9           “(A) a member of the American Academy  
10       of Actuaries; or

11       “(B) a qualified loss reserve specialist.

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

15       “(1) the solicitation or sale of individual health  
16       insurance coverage by a health insurance issuer to  
17       any person or group who is not eligible for such in-  
18       surance; or

19       “(2) the solicitation or sale of individual health  
20       insurance coverage that violates the requirements of  
21       the law of a secondary State which are described in  
22       subparagraphs (A) through (H) of section  
23       2796(b)(1).

24       “(i) POWER OF SECONDARY STATES TO TAKE AD-  
25       MINISTRATIVE ACTION.—Nothing in this section shall be

1 construed to affect the authority of any State to enjoin  
2 conduct in violation of that State's laws described in sec-  
3 tion 2796(b)(1).

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

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

12 “(2) COURTS OF COMPETENT JURISDICTION.—

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

17 “(k) STATES' AUTHORITY TO SUE.—Nothing in this  
18 section shall affect the authority of any State to bring ac-  
19 tion in any Federal or State court.

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

24 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO  
25 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a

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

12 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
13 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
14 **STATES.**

15 “A health insurance issuer may not offer, sell, or  
16 issue individual health insurance coverage in a secondary  
17 State if the State insurance commissioner does not use  
18 a risk-based capital formula for the determination of cap-  
19 ital and surplus requirements for all health insurance  
20 issuers.

21 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
22 **DURES.**

23 “(a) RIGHT TO EXTERNAL APPEAL.— A health in-  
24 surance issuer may not offer, sell, or issue individual

1 health insurance coverage in a secondary State under the  
2 provisions of this title unless—

3 “(1) both the secondary State and the primary  
4 State have legislation or regulations in place estab-  
5 lishing an independent review process for individuals  
6 who are covered by individual health insurance cov-  
7 erage, or

8 “(2) in any case in which the requirements of  
9 subparagraph (A) are not met with respect to the ei-  
10 ther of such States, the issuer provides an inde-  
11 pendent review mechanism substantially identical (as  
12 determined by the applicable State authority of such  
13 State) to that prescribed in the ‘Health Carrier Ex-  
14 ternal Review Model Act’ of the National Association  
15 of Insurance Commissioners for all individuals who  
16 purchase insurance coverage under the terms of this  
17 part, except that, under such mechanism, the review  
18 is conducted by an independent medical reviewer, or  
19 a panel of such reviewers, with respect to whom the  
20 requirements of subsection (b) are met.

21 “(b) QUALIFICATIONS OF INDEPENDENT MEDICAL  
22 REVIEWERS.— In the case of any independent review  
23 mechanism referred to in subsection (a)(2)—

24 “(1) IN GENERAL.—In referring a denial of a  
25 claim to an independent medical reviewer, or to any

1 panel of such reviewers, to conduct independent  
2 medical review, the issuer shall ensure that—

3 “(A) each independent medical reviewer  
4 meets the qualifications described in paragraphs  
5 (2) and (3);

6 “(B) with respect to each review, each re-  
7 viewer meets the requirements of paragraph (4)  
8 and the reviewer, or at least 1 reviewer on the  
9 panel, meets the requirements described in  
10 paragraph (5); and

11 “(C) compensation provided by the issuer  
12 to each reviewer is consistent with paragraph  
13 (6).

14 “(2) LICENSURE AND EXPERTISE.—Each inde-  
15 pendent medical reviewer shall be a physician  
16 (allopathic or osteopathic) or health care profes-  
17 sional who—

18 “(A) is appropriately credentialed or li-  
19 censed in 1 or more States to deliver health  
20 care services; and

21 “(B) typically treats the condition, makes  
22 the diagnosis, or provides the type of treatment  
23 under review.

24 “(3) INDEPENDENCE.—

1           “(A) IN GENERAL.—Subject to subpara-  
2           graph (B), each independent medical reviewer  
3           in a case shall—

4                   “(i) not be a related party (as defined  
5                   in paragraph (7));

6                   “(ii) not have a material familial, fi-  
7                   nancial, or professional relationship with  
8                   such a party; and

9                   “(iii) not otherwise have a conflict of  
10                  interest with such a party (as determined  
11                  under regulations).

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

14                   “(i) prohibit an individual, solely on  
15                   the basis of affiliation with the issuer,  
16                   from serving as an independent medical re-  
17                   viewer if—

18                           “(I) a non-affiliated individual is  
19                           not reasonably available;

20                           “(II) the affiliated individual is  
21                           not involved in the provision of items  
22                           or services in the case under review;

23                           “(III) the fact of such an affili-  
24                           ation is disclosed to the issuer and the

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

3 “(IV) the affiliated individual is  
4 not an employee of the issuer and  
5 does not provide services exclusively or  
6 primarily to or on behalf of the issuer;

7 “(ii) prohibit an individual who has  
8 staff privileges at the institution where the  
9 treatment involved takes place from serv-  
10 ing as an independent medical reviewer  
11 merely on the basis of such affiliation if  
12 the affiliation is disclosed to the issuer and  
13 the enrollee (or authorized representative),  
14 and neither party objects; or

15 “(iii) prohibit receipt of compensation  
16 by an independent medical reviewer from  
17 an entity if the compensation is provided  
18 consistent with paragraph (6).

19 “(4) PRACTICING HEALTH CARE PROFESSIONAL  
20 IN SAME FIELD.—

21 “(A) IN GENERAL.—In a case involving  
22 treatment, or the provision of items or serv-  
23 ices—

24 “(i) by a physician, a reviewer shall be  
25 a practicing physician (allopathic or osteo-

1 pathic) of the same or similar specialty, as  
2 a physician who, acting within the appro-  
3 priate scope of practice within the State in  
4 which the service is provided or rendered,  
5 typically treats the condition, makes the  
6 diagnosis, or provides the type of treat-  
7 ment under review; or

8 “(ii) by a non-physician health care  
9 professional, the reviewer, or at least 1  
10 member of the review panel, shall be a  
11 practicing non-physician health care pro-  
12 fessional of the same or similar specialty  
13 as the non-physician health care profes-  
14 sional who, acting within the appropriate  
15 scope of practice within the State in which  
16 the service is provided or rendered, typi-  
17 cally treats the condition, makes the diag-  
18 nosis, or provides the type of treatment  
19 under review.

20 “(B) PRACTICING DEFINED.—For pur-  
21 poses of this paragraph, the term ‘practicing’  
22 means, with respect to an individual who is a  
23 physician or other health care professional, that  
24 the individual provides health care services to



1 individual patients on average at least 2 days  
2 per week.

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

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

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

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

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

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

19 “(B) The enrollee (or authorized represent-  
20 ative).

21 “(C) The health care professional that pro-  
22 vides the items or services involved in the de-  
23 nial.

1           “(D) The institution at which the items or  
2           services (or treatment) involved in the denial  
3           are provided.

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

7           “(F) Any other party determined under  
8           any regulations to have a substantial interest in  
9           the denial involved.

10          “(8) DEFINITIONS.—For purposes of this sub-  
11          section:

12               “(A) ENROLLEE.—The term ‘enrollee’  
13               means, with respect to health insurance cov-  
14               erage offered by a health insurance issuer, an  
15               individual enrolled with the issuer to receive  
16               such coverage.

17               “(B) HEALTH CARE PROFESSIONAL.—The  
18               term ‘health care professional’ means an indi-  
19               vidual who is licensed, accredited, or certified  
20               under State law to provide specified health care  
21               services and who is operating within the scope  
22               of such licensure, accreditation, or certification.

23          **“SEC. 2799. ENFORCEMENT.**

24               “(a) IN GENERAL.—Subject to subsection (b), with  
25          respect to specific individual health insurance coverage the

1 primary State for such coverage has sole jurisdiction to  
2 enforce the primary State's covered laws in the primary  
3 State and any secondary State.

4 “(b) SECONDARY STATE'S AUTHORITY.—Nothing in  
5 subsection (a) shall be construed to affect the authority  
6 of a secondary State to enforce its laws as set forth in  
7 the exception specified in section 2796(b)(1).

8 “(c) COURT INTERPRETATION.—In reviewing action  
9 initiated by the applicable secondary State authority, the  
10 court of competent jurisdiction shall apply the covered  
11 laws of the primary State.

12 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
13 of individual health insurance coverage offered in a sec-  
14 ondary State that fails to comply with the covered laws  
15 of the primary State, the applicable State authority of the  
16 secondary State may notify the applicable State authority  
17 of the primary State.”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall apply to individual health insurance  
20 coverage offered, issued, or sold after the date that is one  
21 year after the date of the enactment of this Act.

22 (c) GAO ONGOING STUDY AND REPORTS.—

23 (1) STUDY.—The Comptroller General of the  
24 United States shall conduct an ongoing study con-

cerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and underinsured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

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

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

## **TITLE V—ASSOCIATION HEALTH PLANS**

### **SECTION 501. SHORT TITLE.**

This title may be cited as the “Small Business Health Fairness Act of 2009”.

1 **SEC. 502. RULES GOVERNING ASSOCIATION HEALTH**  
2 **PLANS.**

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

6 **“PART 8—RULES GOVERNING ASSOCIATION**  
7 **HEALTH PLANS**

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

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

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

15 “(1) is organized and maintained in good faith,  
16 with a constitution and bylaws specifically stating its  
17 purpose and providing for periodic meetings on at  
18 least an annual basis, for substantial purposes other  
19 than that of obtaining or providing medical care;

20 “(2) is established as a permanent entity which  
21 receives the active support of its members and re-  
22 quires for membership payment on a periodic basis  
23 of dues or payments necessary to maintain eligibility  
24 for membership in the sponsor; and

25 “(3) does not condition membership, such dues  
26 or payments, or coverage under the plan on the

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

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

10 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
11 **PLANS.**

12 “(a) IN GENERAL.—The applicable authority shall  
13 prescribe by regulation a procedure under which, subject  
14 to subsection (b), the applicable authority shall certify as-  
15 sociation health plans which apply for certification as  
16 meeting the requirements of this part.

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

1       “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
2 PLANS.—An association health plan with respect to which  
3 certification under this part is in effect shall meet the ap-  
4 plicable requirements of this part, effective on the date  
5 of certification (or, if later, on the date on which the plan  
6 is to commence operations).

7       “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
8 CATION.—The applicable authority may provide by regula-  
9 tion for continued certification of association health plans  
10 under this part.

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

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

1           “(1) a plan which offered such coverage on the  
2           date of the enactment of the Small Business Health  
3           Fairness Act of 2009,

4           “(2) a plan under which the sponsor does not  
5           restrict membership to one or more trades and busi-  
6           nesses or industries and whose eligible participating  
7           employers represent a broad cross-section of trades  
8           and businesses or industries, or

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



1 posed premium rate levels, or other means dem-  
2 onstrated by such plan in accordance with regula-  
3 tions.

4 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
5 **BOARDS OF TRUSTEES.**

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

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

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

20 “(2) RULES OF OPERATION AND FINANCIAL  
21 CONTROLS.—The board of trustees has in effect  
22 rules of operation and financial controls, based on a  
23 3-year plan of operation, adequate to carry out the  
24 terms of the plan and to meet all requirements of  
25 this title applicable to the plan.

1           “(3) RULES GOVERNING RELATIONSHIP TO  
2 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
3 TORS.—

4           “(A) BOARD MEMBERSHIP.—

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

13           “(ii) LIMITATION.—

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

20           “(II) LIMITED EXCEPTION FOR  
21 PROVIDERS OF SERVICES SOLELY ON  
22 BEHALF OF THE SPONSOR.—Officers  
23 or employees of a sponsor which is a  
24 service provider (other than a contract  
25 administrator) to the plan may be

1 members of the board if they con-  
2 stitute not more than 25 percent of  
3 the membership of the board and they  
4 do not provide services to the plan  
5 other than on behalf of the sponsor.

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

15 “(iii) CERTAIN PLANS EXCLUDED.—  
16 Clause (I) shall not apply to an association  
17 health plan which is in existence on the  
18 date of the enactment of the Small Busi-  
19 ness Health Fairness Act of 2009.

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

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

5           “(1) the requirements of subsection (a) and sec-  
6 tion 801(a) shall be deemed met if such require-  
7 ments would otherwise be met if the franchiser were  
8 deemed to be the sponsor referred to in section  
9 801(b), such network were deemed to be an associa-  
10 tion described in section 801(b), and each franchisee  
11 were deemed to be a member (of the association and  
12 the sponsor) referred to in section 801(b); and

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

15 The Secretary may by regulation define for purposes of  
16 this subsection the terms ‘franchiser’, ‘franchise network’,  
17 and ‘franchisee’.

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 Health Fairness Act of 2009, an affiliated member  
2 of the sponsor of the plan may be offered coverage under  
3 the plan as a participating employer only if—

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

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

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

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



1 issuer offering health insurance coverage in  
2 connection with an association health plan,  
3 from—

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

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

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

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

24 “(4) MARKETING REQUIREMENTS.—

1           “(A) IN GENERAL.—If a benefit option  
2           which consists of health insurance coverage is  
3           offered under the plan, State-licensed insurance  
4           agents shall be used to distribute to small em-  
5           ployers coverage which does not consist of  
6           health insurance coverage in a manner com-  
7           parable to the manner in which such agents are  
8           used to distribute health insurance coverage.

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

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

23          “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
24          DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
25          nothing in this part or any provision of State law (as de-

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

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

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

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

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

1           “(A) establishes and maintains reserves  
2           with respect to such additional benefit options,  
3           in amounts recommended by the qualified actu-  
4           ary, consisting of—

5                   “(I) a reserve sufficient for unearned  
6                   contributions;

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

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

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

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

24                   “(I) The plan shall secure aggregate  
25                   excess/stop loss insurance for the plan with

1 an attachment point which is not greater  
2 than 125 percent of expected gross annual  
3 claims. The applicable authority may by  
4 regulation provide for upward adjustments  
5 in the amount of such percentage in speci-  
6 fied circumstances in which the plan spe-  
7 cifically provides for and maintains re-  
8 serves in excess of the amounts required  
9 under subparagraph (A).

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

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

1 Any person issuing to a plan insurance described in clause  
2 (I), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
3 retary of any failure of premium payment meriting can-  
4 cellation of the policy prior to undertaking such a cancella-  
5 tion. Any regulations prescribed by the applicable author-  
6 ity pursuant to clause (I) or (ii) of subparagraph (B) may  
7 allow for such adjustments in the required levels of excess/  
8 stop loss insurance as the qualified actuary may rec-  
9 ommend, taking into account the specific circumstances  
10 of the plan.

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

16 “(1) \$500,000, or

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

1       “(c) ADDITIONAL REQUIREMENTS.—In the case of  
2 any association health plan described in subsection (a)(2),  
3 the applicable authority may provide such additional re-  
4 quirements relating to reserves, excess/stop loss insurance,  
5 and indemnification insurance as the applicable authority  
6 considers appropriate. Such requirements may be provided  
7 by regulation with respect to any such plan or any class  
8 of such plans.

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

15       “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The  
16 applicable authority may permit an association health plan  
17 described in subsection (a)(2) to substitute, for all or part  
18 of the requirements of this section (except subsection  
19 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-  
20 rangement, or other financial arrangement as the applica-  
21 ble authority determines to be adequate to enable the plan  
22 to fully meet all its financial obligations on a timely basis  
23 and is otherwise no less protective of the interests of par-  
24 ticipants and beneficiaries than the requirements for  
25 which it is substituted. The applicable authority may take

1 into account, for purposes of this subsection, evidence pro-  
2 vided by the plan or sponsor which demonstrates an as-  
3 sumption of liability with respect to the plan. Such evi-  
4 dence may be in the form of a contract of indemnification,  
5 lien, bonding, insurance, letter of credit, recourse under  
6 applicable terms of the plan in the form of assessments  
7 of participating employers, security, or other financial ar-  
8 rangement.

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

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

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



1 advance of certification under this part. Pay-  
2 ments shall continue to accrue until a plan's as-  
3 sets are distributed pursuant to a termination  
4 procedure.

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

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

16 “(2) PAYMENTS BY SECRETARY TO CONTINUE  
17 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-  
18 DEMNIFICATION INSURANCE COVERAGE FOR CER-  
19 TAIN PLANS.—In any case in which the applicable  
20 authority determines that there is, or that there is  
21 reason to believe that there will be: (A) a failure to  
22 take necessary corrective actions under section  
23 809(a) with respect to an association health plan de-  
24 scribed in subsection (a)(2); or (B) a termination of  
25 such a plan under section 809(b) or 810(b)(8) (and,

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

14 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

1           “(B) INVESTMENT.—Whenever the Sec-  
2           retary determines that the moneys of the fund  
3           are in excess of current needs, the Secretary  
4           may request the investment of such amounts as  
5           the Secretary determines advisable by the Sec-  
6           retary of the Treasury in obligations issued or  
7           guaranteed by the United States.

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

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

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

20           “(B) which is guaranteed renewable; and

21           “(C) which allows for payment of pre-  
22           miums by any third party on behalf of the in-  
23           sured plan.

24           “(2) SPECIFIC EXCESS/STOP LOSS INSUR-  
25           ANCE.—The term ‘specific excess/stop loss insur-

1       ance’ means, in connection with an association  
2       health plan, a contract—

3               “(A) under which an insurer (meeting such  
4               minimum standards as the applicable authority  
5               may prescribe by regulation) provides for pay-  
6               ment to the plan with respect to claims under  
7               the plan in connection with a covered individual  
8               in excess of an amount or amounts specified in  
9               such contract in connection with such covered  
10              individual;

11              “(B) which is guaranteed renewable; and

12              “(C) which allows for payment of pre-  
13              miums by any third party on behalf of the in-  
14              sured plan.

15       “(h) INDEMNIFICATION INSURANCE.—For purposes  
16 of this section, the term ‘indemnification insurance’  
17 means, in connection with an association health plan, a  
18 contract—

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

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

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

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

12          “(j) SOLVENCY STANDARDS WORKING GROUP.—

13               “(1) IN GENERAL.—Within 90 days after the  
14               date of the enactment of the Small Business Health  
15               Fairness Act of 2009, the applicable authority shall  
16               establish a Solvency Standards Working Group. In  
17               prescribing the initial regulations under this section,  
18               the applicable authority shall take into account the  
19               recommendations of such Working Group.

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

1                   “(A) a representative of the National Asso-  
2                   ciation of Insurance Commissioners;

3                   “(B) a representative of the American  
4                   Academy of Actuaries;

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

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

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

12                  “(F) a representative of multiemployer  
13                  plans that are group health plans, or their in-  
14                  terests.

15   **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
16                   **LATED REQUIREMENTS.**

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

1       “(b) INFORMATION TO BE INCLUDED IN APPLICA-  
2 TION FOR CERTIFICATION.—An application for certifi-  
3 cation under this part meets the requirements of this sec-  
4 tion only if it includes, in a manner and form which shall  
5 be prescribed by the applicable authority by regulation, at  
6 least the following information:

7           “(1) IDENTIFYING INFORMATION.—The names  
8 and addresses of—

9               “(A) the sponsor; and

10              “(B) the members of the board of trustees  
11 of the plan.

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

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

22           “(4) PLAN DOCUMENTS.—A copy of the docu-  
23 ments governing the plan (including any bylaws and  
24 trust agreements), the summary plan description,  
25 and other material describing the benefits that will

1 be provided to participants and beneficiaries under  
2 the plan.

3 “(5) AGREEMENTS WITH SERVICE PRO-  
4 VIDERS.—A copy of any agreements between the  
5 plan and contract administrators and other service  
6 providers.

7 “(6) FUNDING REPORT.—In the case of asso-  
8 ciation health plans providing benefits options in ad-  
9 dition to health insurance coverage, a report setting  
10 forth information with respect to such additional  
11 benefit options determined as of a date within the  
12 120-day period ending with the date of the applica-  
13 tion, including the following:

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

21 “(B) ADEQUACY OF CONTRIBUTION  
22 RATES.—A statement of actuarial opinion,  
23 signed by a qualified actuary, which sets forth  
24 a description of the extent to which contribution  
25 rates are adequate to provide for the payment



1 of all obligations and the maintenance of re-  
2 quired reserves under the plan for the 12-  
3 month period beginning with such date within  
4 such 120-day period, taking into account the  
5 expected coverage and experience of the plan. If  
6 the contribution rates are not fully adequate,  
7 the statement of actuarial opinion shall indicate  
8 the extent to which the rates are inadequate  
9 and the changes needed to ensure adequacy.

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

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

1                   “(E) OTHER INFORMATION.—Any other  
2                   information as may be determined by the appli-  
3                   cable authority, by regulation, as necessary to  
4                   carry out the purposes of this part.

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

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

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

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

1 whether the contents of the matters reported under this  
2 part—

3 “(1) are in the aggregate reasonably related to  
4 the experience of the plan and to reasonable expecta-  
5 tions; and

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

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

10 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
11 **MINATION.**

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

18 “(1) provides to the participants and bene-  
19 ficiaries a written notice of intent to terminate stat-  
20 ing that such termination is intended and the pro-  
21 posed termination date;

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

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

3   Actions required under this section shall be taken in such  
4   form and manner as may be prescribed by the applicable  
5   authority by regulation.

6   **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
7                           **NATION.**

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

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

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

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

23 “(2) the applicable authority determines that  
24 there is a reasonable expectation that the plan will

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

13   **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
14                   **VENT ASSOCIATION HEALTH PLANS PRO-**  
15                   **VIDING HEALTH BENEFITS IN ADDITION TO**  
16                   **HEALTH INSURANCE COVERAGE.**

17      “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
18      INSOLVENT PLANS.—Whenever the Secretary determines  
19      that an association health plan which is or has been cer-  
20      tified under this part and which is described in section  
21      806(a)(2) will be unable to provide benefits when due or  
22      is otherwise in a financially hazardous condition, as shall  
23      be defined by the Secretary by regulation, the Secretary  
24      shall, upon notice to the plan, apply to the appropriate  
25      United States district court for appointment of the Sec-

1   retary as trustee to administer the plan for the duration  
2   of the insolvency. The plan may appear as a party and  
3   other interested persons may intervene in the proceedings  
4   at the discretion of the court. The court shall appoint such  
5   Secretary trustee if the court determines that the trustee-  
6   ship is necessary to protect the interests of the partici-  
7   pants and beneficiaries or providers of medical care or to  
8   avoid any unreasonable deterioration of the financial con-  
9   dition of the plan. The trusteeship of such Secretary shall  
10   continue until the conditions described in the first sen-  
11   tence of this subsection are remedied or the plan is termi-  
12   nated.

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

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

19           “(2) to require the transfer of all (or any part)  
20       of the assets and records of the plan to the Sec-  
21       retary as trustee;

22           “(3) to invest any assets of the plan which the  
23       Secretary holds in accordance with the provisions of  
24       the plan, regulations prescribed by the Secretary,  
25       and applicable provisions of law;



1           “(4) to require the sponsor, the plan adminis-  
2           trator, any participating employer, and any employee  
3           organization representing plan participants to fur-  
4           nish any information with respect to the plan which  
5           the Secretary as trustee may reasonably need in  
6           order to administer the plan;

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

10          “(6) to commence, prosecute, or defend on be-  
11          half of the plan any suit or proceeding involving the  
12          plan;

13          “(7) to issue, publish, or file such notices, state-  
14          ments, and reports as may be required by the Sec-  
15          retary by regulation or required by any order of the  
16          court;

17          “(8) to terminate the plan (or provide for its  
18          termination in accordance with section 809(b)) and  
19          liquidate the plan assets, to restore the plan to the  
20          responsibility of the sponsor, or to continue the  
21          trusteeship;

22          “(9) to provide for the enrollment of plan par-  
23          ticipants and beneficiaries under appropriate cov-  
24          erage options; and

1           “(10) to do such other acts as may be nec-  
2           essary to comply with this title or any order of the  
3           court and to protect the interests of plan partici-  
4           pants and beneficiaries and providers of medical  
5           care.

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

9           “(1) the sponsor and plan administrator;

10          “(2) each participant;

11          “(3) each participating employer; and

12          “(4) if applicable, each employee organization  
13          which, for purposes of collective bargaining, rep-  
14          resents plan participants.

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

22          “(e) OTHER PROCEEDINGS.—An application by the  
23          Secretary under this subsection may be filed notwith-  
24          standing the pendency in the same or any other court of  
25          any bankruptcy, mortgage foreclosure, or equity receiver-

1 ship proceeding, or any proceeding to reorganize, conserve,  
2 or liquidate such plan or its property, or any proceeding  
3 to enforce a lien against property of the plan.

4 “(f) JURISDICTION OF COURT.—

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

1 sponsor or any other suit against the plan or the  
2 sponsor.

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

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

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

17 “(a) IN GENERAL.—Notwithstanding section 514, a  
18 State may impose by law a contribution tax on an associa-  
19 tion health plan described in section 806(a)(2), if the plan  
20 commenced operations in such State after the date of the  
21 enactment of the Small Business Health Fairness Act of  
22 2009.

23 “(b) CONTRIBUTION TAX.—For purposes of this sec-  
24 tion, the term ‘contribution tax’ imposed by a State on

1 an association health plan means any tax imposed by such  
2 State if—

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

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

15 “(3) such tax is otherwise nondiscriminatory;  
16 and

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

1 care under the plan, or any combination thereof pro-  
2 vided by such insurers or health maintenance organi-  
3 zations in such State in connection with such plan.

4 **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

6 “(1) GROUP HEALTH PLAN.—The term ‘group  
7 health plan’ has the meaning provided in section  
8 733(a)(1) (after applying subsection (b) of this sec-  
9 tion).

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

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

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

18 “(5) APPLICABLE AUTHORITY.—The term ‘ap-  
19 plicable authority’ means the Secretary, except that,  
20 in connection with any exercise of the Secretary’s  
21 authority regarding which the Secretary is required  
22 under section 506(d) to consult with a State, such  
23 term means the Secretary, in consultation with such  
24 State.

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.

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



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

4           “(B) in the case of a sponsor with mem-  
5           bers which consist of associations, a person who  
6           is a member of any such association and elects  
7           an affiliated status with the sponsor, or

8           “(C) in the case of an association health  
9           plan in existence on the date of the enactment  
10          of the Small Business Health Fairness Act of  
11          2009, a person eligible to be a member of the  
12          sponsor or one of its member associations.

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

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

24          “(b) RULES OF CONSTRUCTION.—

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

8                   “(A) in the case of a partnership, the term  
9                   ‘employer’ (as defined in section 3(5)) includes  
10                  the partnership in relation to the partners, and  
11                  the term ‘employee’ (as defined in section 3(6))  
12                  includes any partner in relation to the partner-  
13                  ship; and

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

18           “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
19           AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
20           case of any plan, fund, or program which was estab-  
21           lished or is maintained for the purpose of providing  
22           medical care (through the purchase of insurance or  
23           otherwise) for employees (or their dependents) cov-  
24           ered thereunder and which demonstrates to the Sec-  
25           retary that all requirements for certification under

1       this part would be met with respect to such plan,  
2       fund, or program if such plan, fund, or program  
3       were a group health plan, such plan, fund, or pro-  
4       gram shall be treated for purposes of this title as an  
5       employee welfare benefit plan on and after the date  
6       of such demonstration.”.

7       (b) CONFORMING AMENDMENTS TO PREEMPTION  
8 RULES.—

9           (1) Section 514(b)(6) of such Act (29 U.S.C.  
10       1144(b)(6)) is amended by adding at the end the  
11       following new subparagraph:

12       “(E) The preceding subparagraphs of this paragraph  
13       do not apply with respect to any State law in the case  
14       of an association health plan which is certified under part  
15       8.”.

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

18           (A) in subsection (b)(4), by striking “Sub-  
19       section (a)” and inserting “Subsections (a) and  
20       (d)”;

21           (B) in subsection (b)(5), by striking “sub-  
22       section (a)” in subparagraph (A) and inserting  
23       “subsection (a) of this section and subsections  
24       (a)(2)(B) and (b) of section 805”, and by strik-  
25       ing “subsection (a)” in subparagraph (B) and

1           inserting “subsection (a) of this section or sub-  
2           section (a)(2)(B) or (b) of section 805”;

3                   (C) by redesignating subsection (d) as sub-  
4           section (e); and

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

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

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

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

1       such other employers are participating employers in  
2       such plan.

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

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

20           “(A) providing solvency standards or similar  
21      standards regarding the adequacy of insurer capital,  
22      surplus, reserves, or contributions, or

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

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

4       “(5) For purposes of this subsection, the term ‘asso-  
5 ciation health plan’ has the meaning provided in section  
6 801(a), and the terms ‘health insurance coverage’, ‘par-  
7 ticipating employer’, and ‘health insurance issuer’ have  
8 the meanings provided such terms in section 812, respec-  
9 tively.”.

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

12                   (A) in clause (I)(II), by striking “and” at  
13 the end;

14                   (B) in clause (ii), by inserting “and which  
15 does not provide medical care (within the mean-  
16 ing of section 733(a)(2)),” after “arrange-  
17 ment,”, and by striking “title.” and inserting  
18 “title, and”; and

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

21                   “(iii) subject to subparagraph (E), in the case  
22 of any other employee welfare benefit plan which is  
23 a multiple employer welfare arrangement and which  
24 provides medical care (within the meaning of section

1       733(a)(2)), any law of any State which regulates in-  
2       surance may apply.”.

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

5           (A) by striking “Nothing” and inserting  
6           “(1) Except as provided in paragraph (2), noth-  
7       ing”; and

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

10       “(2) Nothing in any other provision of law enacted  
11       on or after the date of the enactment of the Small Busi-  
12       ness Health Fairness Act of 2009 shall be construed to  
13       alter, amend, modify, invalidate, impair, or supersede any  
14       provision of this title, except by specific cross-reference to  
15       the affected section.”.

16       (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
17       (29 U.S.C. 102(16)(B)) is amended by adding at the end  
18       the following new sentence: “Such term also includes a  
19       person serving as the sponsor of an association health plan  
20       under part 8.”.

21       (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-  
22       LATED TO SELF-INSURED AND FULLY INSURED OPTIONS  
23       UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)  
24       of such Act (29 U.S.C. 102(b)) is amended by adding at  
25       the end the following: “An association health plan shall

1 include in its summary plan description, in connection  
2 with each benefit option, a description of the form of sol-  
3 vency or guarantee fund protection secured pursuant to  
4 this Act or applicable State law, if any.”.

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

7 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
8 CATION OF SELF-INSURED ASSOCIATION HEALTH  
9 PLANS.—Not later than January 1, 2012, the Secretary  
10 of Labor shall report to the Committee on Education and  
11 the Workforce of the House of Representatives and the  
12 Committee on Health, Education, Labor, and Pensions of  
13 the Senate the effect association health plans have had,  
14 if any, on reducing the number of uninsured individuals.

15 (g) CLERICAL AMENDMENT.—The table of contents  
16 in section 1 of the Employee Retirement Income Security  
17 Act of 1974 is amended by inserting after the item relat-  
18 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 pro-  
viding health benefits in addition to health insurance coverage.



“811. State assessment authority.

“812. Definitions and rules of construction.”.

1   **SEC. 503. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
2                   **PLOYER ARRANGEMENTS.**

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

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

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

19               “(iii)(I) in any case in which the benefit re-  
20               ferred to in subparagraph (A) consists of medical  
21               care (as defined in section 812(a)(2)), the deter-  
22               mination of whether a trade or business is under  
23               ‘common control’ with another trade or business  
24               shall be determined under regulations of the Sec-

1       retary applying principles consistent and coextensive  
2       with the principles applied in determining whether  
3       employees of two or more trades or businesses are  
4       treated as employed by a single employer under sec-  
5       tion 4001(b), except that, for purposes of this para-  
6       graph, an interest of greater than 25 percent may  
7       not be required as the minimum interest necessary  
8       for common control, or

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

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

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

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

1        ployees of participating employers and who are cov-  
2        ered under the arrangement,”.

3    **SEC. 504. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
4        **CIATION HEALTH PLANS.**

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

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

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

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

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

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

1 Act (45 U.S.C. 152, paragraph Fourth) or which are  
2 reached pursuant to labor-management negotiations  
3 under similar provisions of State public employee re-  
4 lations laws; or

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

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) ASSOCIATION HEALTH PLAN CEASE AND DE-  
14 SIST ORDERS.—

15 “(1) IN GENERAL.—Subject to paragraph (2),  
16 upon application by the Secretary showing the oper-  
17 ation, promotion, or marketing of an association  
18 health plan (or similar arrangement providing bene-  
19 fits consisting of medical care (as defined in section  
20 733(a)(2))) that—

21 “(A) is not certified under part 8, is sub-  
22 ject under section 514(b)(6) to the insurance  
23 laws of any State in which the plan or arrange-  
24 ment offers or provides benefits, and is not li-

1 censed, registered, or otherwise approved under  
2 the insurance laws of such State; or

3 “(B) is an association health plan certified  
4 under part 8 and is not operating in accordance  
5 with the requirements under part 8 for such  
6 certification,

7 a district court of the United States shall enter an  
8 order requiring that the plan or arrangement cease  
9 activities.

10 “(2) EXCEPTION.—Paragraph (1) shall not  
11 apply in the case of an association health plan or  
12 other arrangement if the plan or arrangement shows  
13 that—

14 “(A) all benefits under it referred to in  
15 paragraph (1) consist of health insurance cov-  
16 erage; and

17 “(B) with respect to each State in which  
18 the plan or arrangement offers or provides ben-  
19 efits, the plan or arrangement is operating in  
20 accordance with applicable State laws that are  
21 not superseded under section 514.

22 “(3) ADDITIONAL EQUITABLE RELIEF.—The  
23 court may grant such additional equitable relief, in-  
24 cluding any relief available under this title, as it  
25 deems necessary to protect the interests of the pub-

1       lic and of persons having claims for benefits against  
2       the plan.”.

3       (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—

4       Section 503 of such Act (29 U.S.C. 1133) is amended by  
5       inserting “(a) IN GENERAL.—” before “In accordance”,  
6       and by adding at the end the following new subsection:

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

13   **SEC. 505. COOPERATION BETWEEN FEDERAL AND STATE**  
14                   **AUTHORITIES.**

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

18      “(d) CONSULTATION WITH STATES WITH RESPECT  
19      TO ASSOCIATION HEALTH PLANS.—

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

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

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

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

14               “(A) in the case of a plan which provides  
15               health insurance coverage (as defined in section  
16               812(a)(3)), such State shall be the State with  
17               which filing and approval of a policy type of-  
18               fered by the plan was initially obtained, and

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

1   **SEC. 506. EFFECTIVE DATE AND TRANSITIONAL AND**  
2                   **OTHER RULES.**

3           (a) **EFFECTIVE DATE.**—The amendments made by  
4 this Act shall take effect 1 year after the date of the enact-  
5 ment of this Act. The Secretary of Labor shall first issue  
6 all regulations necessary to carry out the amendments  
7 made by this Act within 1 year after the date of the enact-  
8 ment of this Act.

9           (b) **TREATMENT OF CERTAIN EXISTING HEALTH**  
10 **BENEFITS PROGRAMS.**—

11           (1) **IN GENERAL.**—In any case in which, as of  
12 the date of the enactment of this Act, an arrange-  
13 ment is maintained in a State for the purpose of  
14 providing benefits consisting of medical care for the  
15 employees and beneficiaries of its participating em-  
16 ployers, at least 200 participating employers make  
17 contributions to such arrangement, such arrange-  
18 ment has been in existence for at least 10 years, and  
19 such arrangement is licensed under the laws of one  
20 or more States to provide such benefits to its par-  
21 ticipating employers, upon the filing with the appli-  
22 cable authority (as defined in section 812(a)(5) of  
23 the Employee Retirement Income Security Act of  
24 1974 (as amended by this subtitle)) by the arrange-  
25 ment of an application for certification of the ar-



1       rangement under part 8 of subtitle B of title I of  
2       such Act—

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

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

10              (C) the requirements of section 803(b) of  
11       such Act shall be deemed met, if the arrange-  
12       ment is operated by a board of directors  
13       which—

14                      (i) is elected by the participating em-  
15       ployers, with each employer having one  
16       vote; and

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

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

23              (E) the arrangement may be certified by  
24       any applicable authority with respect to its op-

1           erations in any State only if it operates in such  
2           State on the date of certification.

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

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