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**AMENDMENT TO THE AMENDMENT IN THE  
NATURE OF A SUBSTITUTE TO H.R. 4872  
OFFERED BY MR. BROUN OF GEORGIA**

Strike the text of the Amendment in the Nature of  
a Substitute beginning on page 1, line 1, through page  
153, line 16, and insert the following:

**1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS; CON-  
2 STRUCTION.**

3 (a) SHORT TITLE.—This Act may be cited as the  
4 “Offering Patients True Individualized Options Act of  
5 2010” or the “OPTION Act of 2010”.

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

- Sec. 1. Short title; table of contents; construction.
- Sec. 2. Repeal of the Patient Protection and Affordable Care Act.

**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 **SEC. 2. REPEAL OF THE PATIENT PROTECTION AND AF-**  
6 **FORDABLE CARE ACT.**

7 The Patient Protection and Affordable Care Act (in-  
8 cluding the amendments made by such Act) is repealed,  
9 and any provision of law amended or repealed by such Act  
10 is hereby restored or revived as if such Act had not been  
11 enacted into law.

12 **TITLE I—HEALTH CARE TAX**  
13 **REFORM**

14 **SEC. 101. ELIMINATION OF 7.5-PERCENT FLOOR ON MED-**  
15 **ICAL EXPENSE DEDUCTIONS.**

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

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

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

7 **SEC. 102. REPEAL OF PRESCRIBED DRUG LIMITATION ON**  
8 **DEDUCTION FOR MEDICAL CARE.**

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

11 (b) CONFORMING AMENDMENT.—Subsection (d) of  
12 section 213 of such Code is amended by striking para-  
13 graph (3).

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

17 **SEC. 103. REPEAL OF 2-PERCENT MISCELLANEOUS**  
18 **ITEMIZED DEDUCTION FLOOR FOR MEDICAL**  
19 **EXPENSE DEDUCTIONS.**

20 (a) IN GENERAL.—Subsection (b) of section 67 of the  
21 Internal Revenue Code of 1986 is amended by striking  
22 paragraph (5).

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

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

2 (a) INCREASE IN DEDUCTIBLE CONTRIBUTION LIM-  
3 TATIONS.—

4 (1) IN GENERAL.—Paragraph (2) of section  
5 223(b) of the Internal Revenue Code of 1986 is  
6 amended—

7 (A) in subparagraph (A) by striking  
8 “\$2,250” and inserting “the amount in effect  
9 for such month under subsection  
10 (c)(2)(A)(ii)(I)”, and

11 (B) in subparagraph (B) by striking  
12 “\$4,500” and inserting “the amount in effect  
13 for such month under subsection  
14 (c)(2)(A)(ii)(II)”.

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

18 (b) MEDICARE ELIGIBLE INDIVIDUALS ELIGIBLE TO  
19 CONTRIBUTE TO HSA.—

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

22 (2) Paragraph (1) of section 223(c) of such  
23 Code is amended by adding at the end the following  
24 new subparagraph:

1           “(C) SPECIAL RULE FOR INDIVIDUALS EN-  
2           TITLED TO BENEFITS UNDER MEDICARE.—In  
3           the case of an individual—

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

6                           “(ii) with respect to whom a health  
7                           savings account is established in a month  
8                           before the first month such individual is  
9                           entitled to such benefits,

10                   such individual shall be deemed to be an eligible  
11                   individual.”.

12           (c) ROLLOVER TO MEDICARE ADVANTAGE MSA.—

13                   (1) IN GENERAL.—Paragraph (2) of section  
14                   138(b) of such Code is amended by striking “or” at  
15                   the end of subparagraph (A), by adding “or” at the  
16                   end of subparagraph (C), and by adding at the end  
17                   the following new subparagraph:

18                           “(C) a HSA rollover contribution described  
19                           in subsection (d)(5).”.

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

23                           “(5) ROLLOVER CONTRIBUTION.—An amount is  
24                           described in this paragraph as a rollover contribu-

1       tion if it meets the requirement of subparagraphs  
2       (A) and (B).

3               “(A) IN GENERAL.—The requirements of  
4       this subparagraph are met in the case of an  
5       amount paid or distributed from a health sav-  
6       ings to the account beneficiary to the extent the  
7       amount is received is paid into a Medicare Ad-  
8       vantage MSA of such beneficiary not later than  
9       the 60th day after the day on which the bene-  
10      ficiary receives the payment or distribution.

11              “(B) LIMITATION.—This paragraph shall  
12      not apply to any amount described in subpara-  
13      graph (A) received by an individual from a  
14      health savings account if, at any time during  
15      the 1-year period ending on the day of such re-  
16      ceipt, such individual received any other amount  
17      described in subparagraph (A) from a health  
18      savings account which was not includible in the  
19      individual’s gross income because of the appli-  
20      cation of section 223(f)(5)(A).”.

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

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

4 **SEC. 105. CHARITY CARE CREDIT.**

5 (a) IN GENERAL.—Subpart A of part IV of sub-  
 6 chapter A of chapter 1 of the Internal Revenue Code of  
 7 1986 (relating to nonrefundable personal credits) is  
 8 amended by inserting after section 25D the following new  
 9 section:

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

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

<b>“If the physician has provided during such taxable year:</b>	<b>The amount of the credit is:</b>
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)).”.

11       (b) CONFORMING AMENDMENT.—The table of sec-  
12 tions for subpart A of part IV of subchapter A of chapter  
13 1 of such Code is amended by inserting after the item  
14 relating to section 25D the following new item:

“Sec. 25E. Charity care credit.”.

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

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

19       (a) UNDER IRC.—Subparagraph (B) of section  
20 4980B(f)(2) of the Internal Revenue Code of 1986 is

1 amended by striking clauses (i) and (v) and by redesignig-  
2 nating clauses (ii), (iii), and (iv) as clauses (i), (ii), and  
3 (iii), respectively.

4 (b) UNDER ERISA.—Paragraph (2) of section 602  
5 of the Employee Retirement Income Security Act of 2009  
6 (29 U.S.C. 1162) is amended by striking subparagraphs  
7 (A) and (E) and by redesignating subparagraphs (B), (C),  
8 and (D) as subparagraphs (A), (B), and (C), respectively.

9 (c) UNDER PHSA.—Paragraph (2) of section  
10 2202(2) of the Public Health Service Act (42 U.S.C.  
11 300bb-2(2)) is amended by striking subparagraphs (A)  
12 and (E) and by redesignating subparagraphs (B), (C), and  
13 (D) as subparagraphs (A), (B), and (C), respectively.

14 (d) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply with respect to group health plans,  
16 and health insurance coverage offered in connection with  
17 group health plans, for plan years beginning after the date  
18 of the enactment of this Act.

19 **SEC. 107. HSA CHARITABLE CONTRIBUTIONS.**

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

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

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

5           “(B) QUALIFIED CHARITABLE DISTRIBU-  
6 TION.—For purposes of this paragraph, the  
7 term ‘qualified charitable distribution’ means  
8 any distribution from a health savings account  
9 which is made directly by the trustee to an or-  
10 ganization described in section 170(b)(1)(A)  
11 (other than any organization described in sec-  
12 tion 509(a)(3) or any fund or account described  
13 in section 4966(d)(2)). A distribution shall be  
14 treated as a qualified charitable distribution  
15 only to the extent that the distribution would be  
16 includible in gross income without regard to  
17 subparagraph (A).

18           “(C) CONTRIBUTIONS MUST BE OTHER-  
19 WISE DEDUCTIBLE.—For purposes of this para-  
20 graph, a distribution to an organization de-  
21 scribed in subparagraph (B) shall be treated as  
22 a qualified charitable distribution only if a de-  
23 duction for the entire distribution would be al-  
24 lowable under section 170 (determined without

1 regard to subsection (b) thereof and this para-  
2 graph).

3 “(D) DENIAL OF DEDUCTION.—Qualified  
4 charitable distributions which are not includible  
5 in gross income pursuant to subparagraph (A)  
6 shall not be taken into account in determining  
7 the deduction under section 170.”.

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

## 11 **TITLE II—MEDICARE VOUCHER** 12 **PROGRAM**

### 13 **SEC. 201. REPLACEMENT OF MEDICARE PART A ENTITLE-** 14 **MENT WITH MEDICARE REFORM VOUCHER** 15 **PROGRAM.**

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

19 “(k) REPLACEMENT OF ENTITLEMENT WITH  
20 VOUCHER PROGRAM.—

21 “(1) IN GENERAL.—Notwithstanding the pre-  
22 vious provisions of this section, beginning the first  
23 January 1 after the date of the enactment of the Of-  
24 fering Patients True Individualized Options Act of  
25 2009, the Secretary shall establish a procedure

1 under which an individual otherwise entitled under  
2 subsection (a) to benefits under part A of title  
3 XVIII shall in lieu of such entitlement be automati-  
4 cally enrolled in the Medicare Reform Voucher Pro-  
5 gram established under subsection (1).

6 “(2) TREATMENT UNDER THE INTERNAL REV-  
7 ENUE CODE OF 1986.—An individual who is enrolled  
8 under the Medicare Reform Voucher Program under  
9 paragraph (1) shall not be treated as entitled to ben-  
10 efits under title XVIII for purposes of section  
11 223(b)(7) of the Internal Revenue Code of 1986.

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

17 “(1) MEDICARE REFORM VOUCHER PROGRAM.—

18 “(1) ESTABLISHMENT OF PROGRAM.—The Sec-  
19 retary shall establish a program to be known as the  
20 Medicare Reform Voucher Program (in this sub-  
21 section referred to as the ‘voucher program’) con-  
22 sistent with this subsection.

23 “(2) AUTOMATIC ENROLLMENT.—An individual  
24 otherwise entitled under subsection (a) to benefits  
25 under part A of title XVIII shall be enrolled in the

1 voucher program for the period during which such  
2 individual would otherwise be so entitled to benefits.

3 “(3) AMOUNT OF VOUCHER.—

4 “(A) IN GENERAL.—Subject to clause (ii),  
5 for each year that an individual is enrolled in  
6 the voucher program, the Secretary shall pro-  
7 vide a voucher to such individual in an amount  
8 determined by the Secretary that is based on  
9 the geographic location of the individual and  
10 the cost of applicable health insurance coverage  
11 and benefits in such area.

12 “(B) COMPUTATION OF VOUCHER  
13 AMOUNTS.—The amount of a voucher provided  
14 to an individual located in a geographic area for  
15 a year shall be computed at 120 percent of the  
16 sum of the median premium and median de-  
17 ductible payment for such year for all health in-  
18 surance coverage offered by health insurance  
19 issuers in the individual market serving such  
20 area.

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

24 “(A) For payment of premiums,  
25 deductibles, copayments, or other cost-sharing

1 for enrollment of such individual for health in-  
2 surance coverage offered by health insurance  
3 issuers in the individual market.

4 “(B) As a contribution into a MSA plan  
5 established by such individual, as defined in  
6 section 138(b)(2) of the Internal Revenue Code  
7 of 1986.

8 “(5) MSA DEPOSITS.—Each voucher amount  
9 received by an individual under this subsection shall  
10 be deposited, on behalf of such individual, into the  
11 MSA plan of such individual.”.

12 (b) EFFECTIVE DATE.—The amendment made by  
13 this section shall take effect on the first January 1 after  
14 the date of the enactment of this Act and shall apply to  
15 an individual who becomes entitled to benefits under part  
16 A of title XVIII of the Social Security Act on or after  
17 such January 1.

## 18 **TITLE III—EMTALA REFORMS**

### 19 **SEC. 301. EMTALA REFORMS.**

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

1 (1) by designating the sentence beginning with  
2 “In the case of” as paragraph (1), with the heading  
3 “IN GENERAL.—” and appropriate indentation; and  
4 (2) by adding at the end the following new  
5 paragraph:

6 “(2) PERMITTING APPLICATION OF ER  
7 TRIAGE.—

8 “(A) IN GENERAL.—The requirement of  
9 paragraph (1) that a hospital conduct an appro-  
10 priate medical screening examination of an indi-  
11 vidual is deemed to be satisfied if a qualified  
12 emergency screener (as defined in subparagraph  
13 (B)) performs a preliminary triage-type screen-  
14 ing in which the personnel—

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

17 “(ii) determines, based on such as-  
18 sessment, that an emergency medical con-  
19 dition does not exist.

20 “(B) QUALIFIED EMERGENCY SCREENER  
21 DEFINED.—In this paragraph, the term ‘quali-  
22 fied emergency screener’ means a physician, li-  
23 censed practical nurse or registered nurse,  
24 qualified emergency medical technician, or other  
25 individual with basic, health care education that

1           meets standards specified by the Secretary as  
2           being sufficient to perform the screening de-  
3           scribed in subparagraph (A).”.

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

7                   “(A) a medical condition manifesting itself  
8           by symptoms of sufficient severity (including se-  
9           vere pain) and with an onset or of a course  
10          such that the absence of immediate medical at-  
11          tention could reasonably be expected to pose an  
12          immediate risk to life or long-term health of the  
13          individual (or, with respect to a pregnant  
14          woman, the life or long-term health of the  
15          woman or her unborn child); or”.

16          (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall take effect on the date of the enactment  
18 of this Act and shall apply to individuals who come to an  
19 emergency room on or after the date that is 30 days after  
20 the date of the enactment of this Act.

1 **TITLE IV—COOPERATIVE GOV-**  
2 **ERNING OF INDIVIDUAL**  
3 **HEALTH INSURANCE COV-**  
4 **ERAGE**

5 **SEC. 401. COOPERATIVE GOVERNING OF INDIVIDUAL**  
6 **HEALTH INSURANCE COVERAGE.**

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

10 **“PART D—COOPERATIVE GOVERNING OF**  
11 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

12 **“SEC. 2795. DEFINITIONS.**

13 “In this part:

14 “(1) PRIMARY STATE.—The term ‘primary  
15 State’ means, with respect to individual health insur-  
16 ance coverage offered by a health insurance issuer,  
17 the State designated by the issuer as the State  
18 whose covered laws shall govern the health insurance  
19 issuer in the sale of such coverage under this part.  
20 An issuer, with respect to a particular policy, may  
21 only designate one such State as its primary State  
22 with respect to all such coverage it offers. Such an  
23 issuer may not change the designated primary State  
24 with respect to individual health insurance coverage  
25 once the policy is issued, except that such a change

1       may be made upon renewal of the policy. With re-  
2       spect to such designated State, the issuer is deemed  
3       to be doing business in that State.

4               “(2) SECONDARY STATE.—The term ‘secondary  
5       State’ means, with respect to individual health insur-  
6       ance coverage offered by a health insurance issuer,  
7       any State that is not the primary State. In the case  
8       of a health insurance issuer that is selling a policy  
9       in, or to a resident of, a secondary State, the issuer  
10       is deemed to be doing business in that secondary  
11       State.

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

18               “(4) INDIVIDUAL HEALTH INSURANCE COV-  
19       ERAGE.—The term ‘individual health insurance cov-  
20       erage’ means health insurance coverage offered in  
21       the individual market, as defined in section  
22       2791(e)(1).

23               “(5) APPLICABLE STATE AUTHORITY.—The  
24       term ‘applicable State authority’ means, with respect  
25       to a health insurance issuer in a State, the State in-

1 insurance commissioner or official or officials des-  
2 ignated by the State to enforce the requirements of  
3 this title for the State with respect to the issuer.

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

9 “(A) to meet obligations to policyholders  
10 with respect to known claims and reasonably  
11 anticipated claims; or

12 “(B) to pay other obligations in the normal  
13 course of business.

14 “(7) COVERED LAWS.—

15 “(A) IN GENERAL.—The term ‘covered  
16 laws’ means the laws, rules, regulations, agree-  
17 ments, and orders governing the insurance busi-  
18 ness pertaining to—

19 “(i) individual health insurance cov-  
20 erage issued by a health insurance issuer;

21 “(ii) the offer, sale, rating (including  
22 medical underwriting), renewal, and  
23 issuance of individual health insurance cov-  
24 erage to an individual;

1           “(iii) the provision to an individual in  
2           relation to individual health insurance cov-  
3           erage of health care and insurance related  
4           services;

5           “(iv) the provision to an individual in  
6           relation to individual health insurance cov-  
7           erage of management, operations, and in-  
8           vestment activities of a health insurance  
9           issuer; and

10          “(v) the provision to an individual in  
11          relation to individual health insurance cov-  
12          erage of loss control and claims adminis-  
13          tration for a health insurance issuer with  
14          respect to liability for which the issuer pro-  
15          vides insurance.

16          “(B) EXCEPTION.—Such term does not in-  
17          clude any law, rule, regulation, agreement, or  
18          order governing the use of care or cost manage-  
19          ment techniques, including any requirement re-  
20          lated to provider contracting, network access or  
21          adequacy, health care data collection, or quality  
22          assurance.

23          “(8) STATE.—The term ‘State’ means the 50  
24          States and includes the District of Columbia, Puerto

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

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

6 “(A) Knowingly misrepresenting to claim-  
7 ants and insured individuals relevant facts or  
8 policy provisions relating to coverage at issue.

9 “(B) Failing to acknowledge with reason-  
10 able promptness pertinent communications with  
11 respect to claims arising under policies.

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

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

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

20 “(F) Failing to affirm or deny coverage of  
21 claims within a reasonable period of time after  
22 having completed an investigation related to  
23 those claims.

24 “(G) A pattern or practice of compelling  
25 insured individuals or their beneficiaries to in-

1           stitute suits to recover amounts due under its  
2           policies by offering substantially less than the  
3           amounts ultimately recovered in suits brought  
4           by them.

5           “(H) A pattern or practice of attempting  
6           to settle or settling claims for less than the  
7           amount that a reasonable person would believe  
8           the insured individual or his or her beneficiary  
9           was entitled by reference to written or printed  
10          advertising material accompanying or made  
11          part of an application.

12          “(I) Attempting to settle or settling claims  
13          on the basis of an application that was materi-  
14          ally altered without notice to, or knowledge or  
15          consent of, the insured.

16          “(J) Failing to provide forms necessary to  
17          present claims within 15 calendar days of a re-  
18          quests with reasonable explanations regarding  
19          their use.

20          “(K) Attempting to cancel a policy in less  
21          time than that prescribed in the policy or by the  
22          law of the primary State.

23          “(10) FRAUD AND ABUSE.—The term ‘fraud  
24          and abuse’ means an act or omission committed by  
25          a person who, knowingly and with intent to defraud,

1       commits, or conceals any material information con-  
2       cerning, one or more of the following:

3               “(A) Presenting, causing to be presented  
4               or preparing with knowledge or belief that it  
5               will be presented to or by an insurer, a rein-  
6               surer, broker or its agent, false information as  
7               part of, in support of or concerning a fact ma-  
8               terial to one or more of the following:

9                       “(i) An application for the issuance or  
10                      renewal of an insurance policy or reinsur-  
11                      ance contract.

12                     “(ii) The rating of an insurance policy  
13                     or reinsurance contract.

14                     “(iii) A claim for payment or benefit  
15                     pursuant to an insurance policy or reinsur-  
16                     ance contract.

17                     “(iv) Premiums paid on an insurance  
18                     policy or reinsurance contract.

19                     “(v) Payments made in accordance  
20                     with the terms of an insurance policy or  
21                     reinsurance contract.

22                     “(vi) A document filed with the com-  
23                     missioner or the chief insurance regulatory  
24                     official of another jurisdiction.

1                   “(vii) The financial condition of an in-  
2                   surer or reinsurer.

3                   “(viii) The formation, acquisition,  
4                   merger, reconsolidation, dissolution or  
5                   withdrawal from one or more lines of in-  
6                   surance or reinsurance in all or part of a  
7                   State by an insurer or reinsurer.

8                   “(ix) The issuance of written evidence  
9                   of insurance.

10                  “(x) The reinstatement of an insur-  
11                  ance policy.

12                  “(B) Solicitation or acceptance of new or  
13                  renewal insurance risks on behalf of an insurer  
14                  reinsurer or other person engaged in the busi-  
15                  ness of insurance by a person who knows or  
16                  should know that the insurer or other person  
17                  responsible for the risk is insolvent at the time  
18                  of the transaction.

19                  “(C) Transaction of the business of insur-  
20                  ance in violation of laws requiring a license, cer-  
21                  tificate of authority or other legal authority for  
22                  the transaction of the business of insurance.

23                  “(D) Attempt to commit, aiding or abet-  
24                  ting in the commission of, or conspiracy to com-

1           mit the acts or omissions specified in this para-  
2           graph.

3 **“SEC. 2796. APPLICATION OF LAW.**

4           “(a) IN GENERAL.—The covered laws of the primary  
5 State shall apply to individual health insurance coverage  
6 offered by a health insurance issuer in the primary State  
7 and in any secondary State, but only if the coverage and  
8 issuer comply with the conditions of this section with re-  
9 spect to the offering of coverage in any secondary State.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8           “(2) require any individual health insurance  
9           coverage issued by the issuer to be countersigned by  
10          an insurance agent or broker residing in that Sec-  
11          ondary State; or

12          “(3) otherwise discriminate against the issuer  
13          issuing insurance in both the primary State and in  
14          any secondary State.

15          “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
16          health insurance issuer shall provide the following notice,  
17          in 12-point bold type, in any insurance coverage offered  
18          in a secondary State under this part by such a health in-  
19          surance issuer and at renewal of the policy, with the 5  
20          blank spaces therein being appropriately filled with the  
21          name of the health insurance issuer, the name of primary  
22          State, the name of the secondary State, the name of the  
23          secondary State, and the name of the secondary State, re-  
24          spectively, for the coverage concerned: ‘Notice: This policy  
25          is issued by \_\_\_\_\_ and is governed by the laws and

1 regulations of the State of \_\_\_\_\_, and it has met all  
2 the laws of that State as determined by that State's De-  
3 partment of Insurance. This policy may be less expensive  
4 than others because it is not subject to all of the insurance  
5 laws and regulations of the State of \_\_\_\_\_, includ-  
6 ing coverage of some services or benefits mandated by the  
7 law of the State of \_\_\_\_\_. Additionally, this policy  
8 is not subject to all of the consumer protection laws or  
9 restrictions on rate changes of the State of \_\_\_\_\_.  
10 As with all insurance products, before purchasing this pol-  
11 icy, you should carefully review the policy and determine  
12 what health care services the policy covers and what bene-  
13 fits it provides, including any exclusions, limitations, or  
14 conditions for such services or benefits.'

15       “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
16 AND PREMIUM INCREASES.—

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

22       “(A) move or reclassify the individual in-  
23 sured under the health insurance coverage from  
24 the class such individual is in at the time of

1 issue of the contract based on the health status-  
2 related factors of the individual; or

3 “(B) increase the premiums assessed the  
4 individual for such coverage based on a health  
5 status-related factor or change of a health sta-  
6 tus-related factor or the past or prospective  
7 claim experience of the insured individual.

8 “(2) CONSTRUCTION.—Nothing in paragraph  
9 (1) shall be construed to prohibit a health insurance  
10 issuer—

11 “(A) from terminating or discontinuing  
12 coverage or a class of coverage in accordance  
13 with subsections (b) and (c) of section 2742;

14 “(B) from raising premium rates for all  
15 policy holders within a class based on claims ex-  
16 perience;

17 “(C) from changing premiums or offering  
18 discounted premiums to individuals who engage  
19 in wellness activities at intervals prescribed by  
20 the issuer, if such premium changes or incen-  
21 tives—

22 “(i) are disclosed to the consumer in  
23 the insurance contract;

1                   “(ii) are based on specific wellness ac-  
2                   tivities that are not applicable to all indi-  
3                   viduals; and

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

6                   “(D) from reinstating lapsed coverage; or

7                   “(E) from retroactively adjusting the rates  
8                   charged an insured individual if the initial rates  
9                   were set based on material misrepresentation by  
10                  the individual at the time of issue.

11               “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
12 STATE.—A health insurance issuer may not offer for sale  
13 individual health insurance coverage in a secondary State  
14 unless that coverage is currently offered for sale in the  
15 primary State.

16               “(f) LICENSING OF AGENTS OR BROKERS FOR  
17 HEALTH INSURANCE ISSUERS.—Any State may require  
18 that a person acting, or offering to act, as an agent or  
19 broker for a health insurance issuer with respect to the  
20 offering of individual health insurance coverage obtain a  
21 license from that State, with commissions or other com-  
22 pensation subject to the provisions of the laws of that  
23 State, except that a State may not impose any qualifica-  
24 tion or requirement which discriminates against a non-  
25 resident agent or broker.

1           “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
2 SURANCE COMMISSIONER.—Each health insurance issuer  
3 issuing individual health insurance coverage in both pri-  
4 mary and secondary States shall submit—

5           “(1) to the insurance commissioner of each  
6 State in which it intends to offer such coverage, be-  
7 fore it may offer individual health insurance cov-  
8 erage in such State—

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

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

16           “(C) written notice from the issuer of the  
17 issuer’s compliance with all the laws of the pri-  
18 mary State; and

19           “(2) to the insurance commissioner of each sec-  
20 ondary State in which it offers individual health in-  
21 surance coverage, a copy of the issuer’s quarterly fi-  
22 nancial statement submitted to the primary State,  
23 which statement shall be certified by an independent  
24 public accountant and contain a statement of opin-

1 ion on loss and loss adjustment expense reserves  
2 made by—

3 “(A) a member of the American Academy  
4 of Actuaries; or

5 “(B) a qualified loss reserve specialist.

6 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—

7 Nothing in this section shall be construed to affect the  
8 authority of any Federal or State court to enjoin—

9 “(1) the solicitation or sale of individual health  
10 insurance coverage by a health insurance issuer to  
11 any person or group who is not eligible for such in-  
12 surance; or

13 “(2) the solicitation or sale of individual health  
14 insurance coverage that violates the requirements of  
15 the law of a secondary State which are described in  
16 subparagraphs (A) through (H) of section  
17 2796(b)(1).

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

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

24 “(1) IN GENERAL.—Subject to the provisions of  
25 subsection (b)(1)(G) (relating to injunctions) and

1 paragraph (2), nothing in this section shall be con-  
2 strued to affect the authority of any State to make  
3 use of any of its powers to enforce the laws of such  
4 State with respect to which a health insurance issuer  
5 is not exempt under subsection (b).

6 “(2) COURTS OF COMPETENT JURISDICTION.—  
7 If a State seeks an injunction regarding the conduct  
8 described in paragraphs (1) and (2) of subsection  
9 (h), such injunction must be obtained from a Fed-  
10 eral or State court of competent jurisdiction.

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

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

18 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO  
19 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a  
20 health insurance issuer is offering coverage in a primary  
21 State that does not accommodate residents of secondary  
22 States or does not provide a working mechanism for resi-  
23 dents of a secondary State, and the issuer is offering cov-  
24 erage under this part in such secondary State which has  
25 not adopted a qualified high risk pool as its acceptable

1 alternative mechanism (as defined in section 2744(c)(2)),  
2 the issuer shall, with respect to any individual health in-  
3 surance coverage offered in a secondary State under this  
4 part, comply with the guaranteed availability requirements  
5 for eligible individuals in section 2741.

6 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
7 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
8 **STATES.**

9 “A health insurance issuer may not offer, sell, or  
10 issue individual health insurance coverage in a secondary  
11 State if the State insurance commissioner does not use  
12 a risk-based capital formula for the determination of cap-  
13 ital and surplus requirements for all health insurance  
14 issuers.

15 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
16 **DURES.**

17 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-  
18 ance issuer may not offer, sell, or issue individual health  
19 insurance coverage in a secondary State under the provi-  
20 sions of this title unless—

21 “(1) both the secondary State and the primary  
22 State have legislation or regulations in place estab-  
23 lishing an independent review process for individuals  
24 who are covered by individual health insurance cov-  
25 erage, or

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

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

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

21                         “(A) each independent medical reviewer  
22                         meets the qualifications described in paragraphs  
23                         (2) and (3);

24                         “(B) with respect to each review, each re-  
25                         viewer meets the requirements of paragraph (4)

1 and the reviewer, or at least 1 reviewer on the  
2 panel, meets the requirements described in  
3 paragraph (5); and

4 “(C) compensation provided by the issuer  
5 to each reviewer is consistent with paragraph  
6 (6).

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

11 “(A) is appropriately credentialed or li-  
12 censed in 1 or more States to deliver health  
13 care services; and

14 “(B) typically treats the condition, makes  
15 the diagnosis, or provides the type of treatment  
16 under review.

17 “(3) INDEPENDENCE.—

18 “(A) IN GENERAL.—Subject to subpara-  
19 graph (B), each independent medical reviewer  
20 in a case shall—

21 “(i) not be a related party (as defined  
22 in paragraph (7));

23 “(ii) not have a material familial, fi-  
24 nancial, or professional relationship with  
25 such a party; and

1                   “(iii) not otherwise have a conflict of  
2                   interest with such a party (as determined  
3                   under regulations).

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

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

10                   “(I) a non-affiliated individual is  
11                   not reasonably available;

12                   “(II) the affiliated individual is  
13                   not involved in the provision of items  
14                   or services in the case under review;

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

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

23                   “(ii) prohibit an individual who has  
24                   staff privileges at the institution where the  
25                   treatment involved takes place from serv-

1           ing as an independent medical reviewer  
2           merely on the basis of such affiliation if  
3           the affiliation is disclosed to the issuer and  
4           the enrollee (or authorized representative),  
5           and neither party objects; or

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

10           “(4) PRACTICING HEALTH CARE PROFESSIONAL  
11           IN SAME FIELD.—

12           “(A) IN GENERAL.—In a case involving  
13           treatment, or the provision of items or serv-  
14           ices—

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

24           “(ii) by a non-physician health care  
25           professional, the reviewer, or at least 1

1 member of the review panel, shall be a  
2 practicing non-physician health care pro-  
3 fessional of the same or similar specialty  
4 as the non-physician health care profes-  
5 sional who, acting within the appropriate  
6 scope of practice within the State in which  
7 the service is provided or rendered, typi-  
8 cally treats the condition, makes the diag-  
9 nosis, or provides the type of treatment  
10 under review.

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

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

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

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

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

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

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

9                   “(B) The enrollee (or authorized represent-  
10                  ative).

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

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

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

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

23           “(8) DEFINITIONS.—For purposes of this sub-  
24           section:

1           “(A) ENROLLEE.—The term ‘enrollee’  
2           means, with respect to health insurance cov-  
3           erage offered by a health insurance issuer, an  
4           individual enrolled with the issuer to receive  
5           such coverage.

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

12   **“SEC. 2799. ENFORCEMENT.**

13          “(a) IN GENERAL.—Subject to subsection (b), with  
14          respect to specific individual health insurance coverage the  
15          primary State for such coverage has sole jurisdiction to  
16          enforce the primary State’s covered laws in the primary  
17          State and any secondary State.

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

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

1           “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
2 of individual health insurance coverage offered in a sec-  
3 ondary State that fails to comply with the covered laws  
4 of the primary State, the applicable State authority of the  
5 secondary State may notify the applicable State authority  
6 of the primary State.”.

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

11          (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

## 9 **TITLE V—ASSOCIATION HEALTH** 10 **PLANS**

### 11 **SEC. 501. SHORT TITLE.**

12 This title may be cited as the “Small Business Health  
13 Fairness Act of 2010”.

### 14 **SEC. 502. RULES GOVERNING ASSOCIATION HEALTH** 15 **PLANS.**

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

### 19 **“PART 8—RULES GOVERNING ASSOCIATION** 20 **HEALTH PLANS**

#### 21 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

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

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

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

8           “(2) is established as a permanent entity which  
9 receives the active support of its members and re-  
10 quires for membership payment on a periodic basis  
11 of dues or payments necessary to maintain eligibility  
12 for membership in the sponsor; and

13           “(3) does not condition membership, such dues  
14 or payments, or coverage under the plan on the  
15 basis of health status-related factors with respect to  
16 the employees of its members (or affiliated mem-  
17 bers), or the dependents of such employees, and does  
18 not condition such dues or payments on the basis of  
19 group health plan participation.

20 Any sponsor consisting of an association of entities which  
21 meet the requirements of paragraphs (1), (2), and (3)  
22 shall be deemed to be a sponsor described in this sub-  
23 section.

1 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
2 **PLANS.**

3 “(a) **IN GENERAL.**—The applicable authority shall  
4 prescribe by regulation a procedure under which, subject  
5 to subsection (b), the applicable authority shall certify as-  
6 sociation health plans which apply for certification as  
7 meeting the requirements of this part.

8 “(b) **STANDARDS.**—Under the procedure prescribed  
9 pursuant to subsection (a), in the case of an association  
10 health plan that provides at least one benefit option which  
11 does not consist of health insurance coverage, the applica-  
12 ble authority shall certify such plan as meeting the re-  
13 quirements of this part only if the applicable authority is  
14 satisfied that the applicable requirements of this part are  
15 met (or, upon the date on which the plan is to commence  
16 operations, will be met) with respect to the plan.

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

23 “(d) **REQUIREMENTS FOR CONTINUED CERTIFI-**  
24 **CATION.**—The applicable authority may provide by regula-  
25 tion for continued certification of association health plans  
26 under this part.

1       “(e) CLASS CERTIFICATION FOR FULLY INSURED  
2 PLANS.—The applicable authority shall establish a class  
3 certification procedure for association health plans under  
4 which all benefits consist of health insurance coverage.  
5 Under such procedure, the applicable authority shall pro-  
6 vide for the granting of certification under this part to  
7 the plans in each class of such association health plans  
8 upon appropriate filing under such procedure in connec-  
9 tion with plans in such class and payment of the pre-  
10 scribed fee under section 807(a).

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

16               “(1) a plan which offered such coverage on the  
17 date of the enactment of the Small Business Health  
18 Fairness Act of 2010,

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

24               “(3) a plan whose eligible participating employ-  
25 ers represent one or more trades or businesses, or

1 one or more industries, consisting of any of the fol-  
2 lowing: agriculture; equipment and automobile deal-  
3 erships; barbering and cosmetology; certified public  
4 accounting practices; child care; construction; dance,  
5 theatrical and orchestra productions; disinfecting  
6 and pest control; financial services; fishing; food  
7 service establishments; hospitals; labor organiza-  
8 tions; logging; manufacturing (metals); mining; med-  
9 ical and dental practices; medical laboratories; pro-  
10 fessional consulting services; sanitary services; trans-  
11 portation (local and freight); warehousing; whole-  
12 saling/distributing; or any other trade or business or  
13 industry which has been indicated as having average  
14 or above-average risk or health claims experience by  
15 reason of State rate filings, denials of coverage, pro-  
16 posed premium rate levels, or other means dem-  
17 onstrated by such plan in accordance with regula-  
18 tions.

19 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
20 **BOARDS OF TRUSTEES.**

21 “(a) SPONSOR.—The requirements of this subsection  
22 are met with respect to an association health plan if the  
23 sponsor has met (or is deemed under this part to have  
24 met) the requirements of section 801(b) for a continuous

1 period of not less than 3 years ending with the date of  
2 the application for certification under this part.

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

6 “(1) FISCAL CONTROL.—The plan is operated,  
7 pursuant to a trust agreement, by a board of trust-  
8 ees which has complete fiscal control over the plan  
9 and which is responsible for all operations of the  
10 plan.

11 “(2) RULES OF OPERATION AND FINANCIAL  
12 CONTROLS.—The board of trustees has in effect  
13 rules of operation and financial controls, based on a  
14 3-year plan of operation, adequate to carry out the  
15 terms of the plan and to meet all requirements of  
16 this title applicable to the plan.

17 “(3) RULES GOVERNING RELATIONSHIP TO  
18 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
19 TORS.—

20 “(A) BOARD MEMBERSHIP.—

21 “(i) IN GENERAL.—Except as pro-  
22 vided in clauses (ii) and (iii), the members  
23 of the board of trustees are individuals se-  
24 lected from individuals who are the owners,  
25 officers, directors, or employees of the par-

1                    participating employers or who are partners in  
2                    the participating employers and actively  
3                    participate in the business.

4                    “(ii) LIMITATION.—

5                          “(I) GENERAL RULE.—Except as  
6                    provided in subclauses (II) and (III),  
7                    no such member is an owner, officer,  
8                    director, or employee of, or partner in,  
9                    a contract administrator or other  
10                    service provider to the plan.

11                          “(II) LIMITED EXCEPTION FOR  
12                    PROVIDERS OF SERVICES SOLELY ON  
13                    BEHALF OF THE SPONSOR.—Officers  
14                    or employees of a sponsor which is a  
15                    service provider (other than a contract  
16                    administrator) to the plan may be  
17                    members of the board if they con-  
18                    stitute not more than 25 percent of  
19                    the membership of the board and they  
20                    do not provide services to the plan  
21                    other than on behalf of the sponsor.

22                          “(III) TREATMENT OF PRO-  
23                    VIDERS OF MEDICAL CARE.—In the  
24                    case of a sponsor which is an associa-  
25                    tion whose membership consists pri-

1           marily of providers of medical care,  
2           subclause (I) shall not apply in the  
3           case of any service provider described  
4           in subclause (I) who is a provider of  
5           medical care under the plan.

6           “(iii) CERTAIN PLANS EXCLUDED.—  
7           Clause (i) shall not apply to an association  
8           health plan which is in existence on the  
9           date of the enactment of the Small Busi-  
10          ness Health Fairness Act of 2010.

11          “(B) SOLE AUTHORITY.—The board has  
12          sole authority under the plan to approve appli-  
13          cations for participation in the plan and to con-  
14          tract with a service provider to administer the  
15          day-to-day affairs of the plan.

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

20                 “(1) the requirements of subsection (a) and sec-  
21                 tion 801(a) shall be deemed met if such require-  
22                 ments would otherwise be met if the franchiser were  
23                 deemed to be the sponsor referred to in section  
24                 801(b), such network were deemed to be an associa-  
25                 tion described in section 801(b), and each franchisee

1       were deemed to be a member (of the association and  
2       the sponsor) referred to in section 801(b); and

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

5 The Secretary may by regulation define for purposes of  
6 this subsection the terms ‘franchiser’, ‘franchise network’,  
7 and ‘franchisee’.

8 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
9                               **MENTS.**

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

14               “(1) each participating employer must be—

15                       “(A) a member of the sponsor,

16                       “(B) the sponsor, or

17                       “(C) an affiliated member of the sponsor  
18       with respect to which the requirements of sub-  
19       section (b) are met,

20       except that, in the case of a sponsor which is a pro-  
21       fessional association or other individual-based asso-  
22       ciation, if at least one of the officers, directors, or  
23       employees of an employer, or at least one of the in-  
24       dividuals who are partners in an employer and who  
25       actively participates in the business, is a member or

1 such an affiliated member of the sponsor, partici-  
2 pating employers may also include such employer;  
3 and

4 “(2) all individuals commencing coverage under  
5 the plan after certification under this part must  
6 be—

7 “(A) active or retired owners (including  
8 self-employed individuals), officers, directors, or  
9 employees of, or partners in, participating em-  
10 ployers; or

11 “(B) the beneficiaries of individuals de-  
12 scribed in subparagraph (A).

13 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
14 PLOYEES.—In the case of an association health plan in  
15 existence on the date of the enactment of the Small Busi-  
16 ness Health Fairness Act of 2010, an affiliated member  
17 of the sponsor of the plan may be offered coverage under  
18 the plan as a participating employer only if—

19 “(1) the affiliated member was an affiliated  
20 member on the date of certification under this part;  
21 or

22 “(2) during the 12-month period preceding the  
23 date of the offering of such coverage, the affiliated  
24 member has not maintained or contributed to a  
25 group health plan with respect to any of its employ-

1       ees who would otherwise be eligible to participate in  
2       such association health plan.

3       “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
4       quirements of this subsection are met with respect to an  
5       association health plan if, under the terms of the plan,  
6       no participating employer may provide health insurance  
7       coverage in the individual market for any employee not  
8       covered under the plan which is similar to the coverage  
9       contemporaneously provided to employees of the employer  
10      under the plan, if such exclusion of the employee from cov-  
11      erage under the plan is based on a health status-related  
12      factor with respect to the employee and such employee  
13      would, but for such exclusion on such basis, be eligible  
14      for coverage under the plan.

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

19           “(1) under the terms of the plan, all employers  
20           meeting the preceding requirements of this section  
21           are eligible to qualify as participating employers for  
22           all geographically available coverage options, unless,  
23           in the case of any such employer, participation or  
24           contribution requirements of the type referred to in

1 section 2711 of the Public Health Service Act are  
2 not met;

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

6 “(3) the applicable requirements of sections  
7 701, 702, and 703 are met with respect to the plan.

8 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
9 **DOCUMENTS, CONTRIBUTION RATES, AND**  
10 **BENEFIT OPTIONS.**

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

14 “(1) CONTENTS OF GOVERNING INSTRU-  
15 MENTS.—The instruments governing the plan in-  
16 clude a written instrument, meeting the require-  
17 ments of an instrument required under section  
18 402(a)(1), which—

19 “(A) provides that the board of trustees  
20 serves as the named fiduciary required for plans  
21 under section 402(a)(1) and serves in the ca-  
22 pacity of a plan administrator (referred to in  
23 section 3(16)(A));

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

4           “(C) incorporates the requirements of sec-  
5           tion 806.

6           “(2) CONTRIBUTION RATES MUST BE NON-  
7           DISCRIMINATORY.—

8           “(A) The contribution rates for any par-  
9           ticipating small employer do not vary on the  
10          basis of any health status-related factor in rela-  
11          tion to employees of such employer or their  
12          beneficiaries and do not vary on the basis of the  
13          type of business or industry in which such em-  
14          ployer is engaged.

15          “(B) Nothing in this title or any other pro-  
16          vision of law shall be construed to preclude an  
17          association health plan, or a health insurance  
18          issuer offering health insurance coverage in  
19          connection with an association health plan,  
20          from—

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

23                  “(ii) varying contribution rates for  
24                  small employers in a State to the extent  
25                  that such rates could vary using the same

1 methodology employed in such State for  
2 regulating premium rates in the small  
3 group market with respect to health insur-  
4 ance coverage offered in connection with  
5 bona fide associations (within the meaning  
6 of section 2791(d)(3) of the Public Health  
7 Service Act),

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

10 “(3) FLOOR FOR NUMBER OF COVERED INDI-  
11 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If  
12 any benefit option under the plan does not consist  
13 of health insurance coverage, the plan has as of the  
14 beginning of the plan year not fewer than 1,000 par-  
15 ticipants and beneficiaries.

16 “(4) MARKETING REQUIREMENTS.—

17 “(A) IN GENERAL.—If a benefit option  
18 which consists of health insurance coverage is  
19 offered under the plan, State-licensed insurance  
20 agents shall be used to distribute to small em-  
21 ployers coverage which does not consist of  
22 health insurance coverage in a manner com-  
23 parable to the manner in which such agents are  
24 used to distribute health insurance coverage.

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

10          “(5)    REGULATORY    REQUIREMENTS.—Such  
11          other requirements as the applicable authority deter-  
12          mines are necessary to carry out the purposes of this  
13          part, which shall be prescribed by the applicable au-  
14          thority by regulation.

15          “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
16          DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
17          nothing in this part or any provision of State law (as de-  
18          fined in section 514(c)(1)) shall be construed to preclude  
19          an association health plan, or a health insurance issuer  
20          offering health insurance coverage in connection with an  
21          association health plan, from exercising its sole discretion  
22          in selecting the specific items and services consisting of  
23          medical care to be included as benefits under such plan  
24          or coverage, except (subject to section 514) in the case  
25          of (1) any law to the extent that it is not preempted under

1 section 731(a)(1) with respect to matters governed by sec-  
2 tion 711, 712, or 713, or (2) any law of the State with  
3 which filing and approval of a policy type offered by the  
4 plan was initially obtained to the extent that such law pro-  
5 hibits an exclusion of a specific disease from such cov-  
6 erage.

7 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
8 **FOR SOLVENCY FOR PLANS PROVIDING**  
9 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
10 **INSURANCE COVERAGE.**

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

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

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

18 “(A) establishes and maintains reserves  
19 with respect to such additional benefit options,  
20 in amounts recommended by the qualified actu-  
21 ary, consisting of—

22 “(i) a reserve sufficient for unearned  
23 contributions;

24 “(ii) a reserve sufficient for benefit li-  
25 abilities which have been incurred, which

1 have not been satisfied, and for which risk  
2 of loss has not yet been transferred, and  
3 for expected administrative costs with re-  
4 spect to such benefit liabilities;

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

7 “(iv) a reserve sufficient for a margin  
8 of error and other fluctuations, taking into  
9 account the specific circumstances of the  
10 plan; and

11 “(B) establishes and maintains aggregate  
12 and specific excess/stop loss insurance and sol-  
13 vency indemnification, with respect to such ad-  
14 ditional benefit options for which risk of loss  
15 has not yet been transferred, as follows:

16 “(i) The plan shall secure aggregate  
17 excess/stop loss insurance for the plan with  
18 an attachment point which is not greater  
19 than 125 percent of expected gross annual  
20 claims. The applicable authority may by  
21 regulation provide for upward adjustments  
22 in the amount of such percentage in speci-  
23 fied circumstances in which the plan spe-  
24 cifically provides for and maintains re-

1 serves in excess of the amounts required  
2 under subparagraph (A).

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

14 “(iii) The plan shall secure indem-  
15 nification insurance for any claims which  
16 the plan is unable to satisfy by reason of  
17 a plan termination.

18 Any person issuing to a plan insurance described in clause  
19 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
20 retary of any failure of premium payment meriting can-  
21 cellation of the policy prior to undertaking such a cancella-  
22 tion. Any regulations prescribed by the applicable author-  
23 ity pursuant to clause (i) or (ii) of subparagraph (B) may  
24 allow for such adjustments in the required levels of excess/  
25 stop loss insurance as the qualified actuary may rec-

1 ommend, taking into account the specific circumstances  
2 of the plan.

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

8           “(1) \$500,000, or

9           “(2) such greater amount (but not greater than  
10 \$2,000,000) as may be set forth in regulations pre-  
11 scribed by the applicable authority, considering the  
12 level of aggregate and specific excess/stop loss insur-  
13 ance provided with respect to such plan and other  
14 factors related to solvency risk, such as the plan’s  
15 projected levels of participation or claims, the nature  
16 of the plan’s liabilities, and the types of assets avail-  
17 able to assure that such liabilities are met.

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

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

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

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

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

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

22               “(B) PENALTIES FOR FAILURE TO MAKE  
23 PAYMENTS.—If any payment is not made by a  
24 plan when it is due, a late payment charge of  
25 not more than 100 percent of the payment

1           which was not timely paid shall be payable by  
2           the plan to the Fund.

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

8           “(2) PAYMENTS BY SECRETARY TO CONTINUE  
9           EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-  
10          DEMNFICATION INSURANCE COVERAGE FOR CER-  
11          TAIN PLANS.—In any case in which the applicable  
12          authority determines that there is, or that there is  
13          reason to believe that there will be: (A) a failure to  
14          take necessary corrective actions under section  
15          809(a) with respect to an association health plan de-  
16          scribed in subsection (a)(2); or (B) a termination of  
17          such a plan under section 809(b) or 810(b)(8) (and,  
18          if the applicable authority is not the Secretary, cer-  
19          tifies such determination to the Secretary), the Sec-  
20          retary shall determine the amounts necessary to  
21          make payments to an insurer (designated by the  
22          Secretary) to maintain in force excess/stop loss in-  
23          surance coverage or indemnification insurance cov-  
24          erage for such plan, if the Secretary determines that  
25          there is a reasonable expectation that, without such

1 payments, claims would not be satisfied by reason of  
2 termination of such coverage. The Secretary shall, to  
3 the extent provided in advance in appropriation  
4 Acts, pay such amounts so determined to the insurer  
5 designated by the Secretary.

6 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

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

19           “(A) under which an insurer (meeting such  
20 minimum standards as the applicable authority  
21 may prescribe by regulation) provides for pay-  
22 ment to the plan with respect to claims under  
23 the plan in connection with a covered individual  
24 in excess of an amount or amounts specified in

1           such contract in connection with such covered  
2           individual;

3           “(B) which is guaranteed renewable; and

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

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

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

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

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

23           “(i) RESERVES.—For purposes of this section, the  
24 term ‘reserves’ means, in connection with an association  
25 health plan, plan assets which meet the fiduciary stand-

1 ards under part 4 and such additional requirements re-  
2 garding liquidity as the applicable authority may prescribe  
3 by regulation.

4 “(j) SOLVENCY STANDARDS WORKING GROUP.—

5 “(1) IN GENERAL.—Within 90 days after the  
6 date of the enactment of the Small Business Health  
7 Fairness Act of 2010, the applicable authority shall  
8 establish a Solvency Standards Working Group. In  
9 prescribing the initial regulations under this section,  
10 the applicable authority shall take into account the  
11 recommendations of such Working Group.

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

18 “(A) a representative of the National Asso-  
19 ciation of Insurance Commissioners;

20 “(B) a representative of the American  
21 Academy of Actuaries;

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

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

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

4           “(F) a representative of multi-employer  
5           plans that are group health plans, or their in-  
6           terests.

7   **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
8                           **LATED REQUIREMENTS.**

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

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

24           “(1) **IDENTIFYING INFORMATION.**—The names  
25           and addresses of—

1           “(A) the sponsor; and

2           “(B) the members of the board of trustees  
3 of the plan.

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

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

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

20           “(5) AGREEMENTS WITH SERVICE PRO-  
21 VIDERS.—A copy of any agreements between the  
22 plan and contract administrators and other service  
23 providers.

24           “(6) FUNDING REPORT.—In the case of asso-  
25 ciation health plans providing benefits options in ad-

1       dition to health insurance coverage, a report setting  
2       forth information with respect to such additional  
3       benefit options determined as of a date within the  
4       120-day period ending with the date of the applica-  
5       tion, including the following:

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

13              “(B) ADEQUACY OF CONTRIBUTION  
14              RATES.—A statement of actuarial opinion,  
15              signed by a qualified actuary, which sets forth  
16              a description of the extent to which contribution  
17              rates are adequate to provide for the payment  
18              of all obligations and the maintenance of re-  
19              quired reserves under the plan for the 12-  
20              month period beginning with such date within  
21              such 120-day period, taking into account the  
22              expected coverage and experience of the plan. If  
23              the contribution rates are not fully adequate,  
24              the statement of actuarial opinion shall indicate

1           the extent to which the rates are inadequate  
2           and the changes needed to ensure adequacy.

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

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

19          “(E) OTHER INFORMATION.—Any other  
20          information as may be determined by the appli-  
21          cable authority, by regulation, as necessary to  
22          carry out the purposes of this part.

23          “(e) FILING NOTICE OF CERTIFICATION WITH  
24          STATES.—A certification granted under this part to an  
25          association health plan shall not be effective unless written

1 notice of such certification is filed with the applicable  
2 State authority of each State in which at least 25 percent  
3 of the participants and beneficiaries under the plan are  
4 located. For purposes of this subsection, an individual  
5 shall be considered to be located in the State in which a  
6 known address of such individual is located or in which  
7 such individual is employed.

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

18       “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
19 SOCIATION HEALTH PLANS.—An association health plan  
20 certified under this part which provides benefit options in  
21 addition to health insurance coverage for such plan year  
22 shall meet the requirements of section 103 by filing an  
23 annual report under such section which shall include infor-  
24 mation described in subsection (b)(6) with respect to the  
25 plan year and, notwithstanding section 104(a)(1)(A), shall

1 be filed with the applicable authority not later than 90  
2 days after the close of the plan year (or on such later date  
3 as may be prescribed by the applicable authority). The ap-  
4 plicable authority may require by regulation such interim  
5 reports as it considers appropriate.

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

19               “(1) are in the aggregate reasonably related to  
20 the experience of the plan and to reasonable expecta-  
21 tions; and

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

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

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
2 **MINATION.**

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

9 “(1) provides to the participants and bene-  
10 ficiaries a written notice of intent to terminate stat-  
11 ing that such termination is intended and the pro-  
12 posed termination date;

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

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

19 Actions required under this section shall be taken in such  
20 form and manner as may be prescribed by the applicable  
21 authority by regulation.

22 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
23 **NATION.**

24 “(a) **ACTIONS TO AVOID DEPLETION OF RE-**  
25 **SERVES.**—An association health plan which is certified  
26 under this part and which provides benefits other than

1 health insurance coverage shall continue to meet the re-  
2 quirements of section 806, irrespective of whether such  
3 certification continues in effect. The board of trustees of  
4 such plan shall determine quarterly whether the require-  
5 ments of section 806 are met. In any case in which the  
6 board determines that there is reason to believe that there  
7 is or will be a failure to meet such requirements, or the  
8 applicable authority makes such a determination and so  
9 notifies the board, the board shall immediately notify the  
10 qualified actuary engaged by the plan, and such actuary  
11 shall, not later than the end of the next following month,  
12 make such recommendations to the board for corrective  
13 action as the actuary determines necessary to ensure com-  
14 pliance with section 806. Not later than 30 days after re-  
15 ceiving from the actuary recommendations for corrective  
16 actions, the board shall notify the applicable authority (in  
17 such form and manner as the applicable authority may  
18 prescribe by regulation) of such recommendations of the  
19 actuary for corrective action, together with a description  
20 of the actions (if any) that the board has taken or plans  
21 to take in response to such recommendations. The board  
22 shall thereafter report to the applicable authority, in such  
23 form and frequency as the applicable authority may speci-  
24 fy to the board, regarding corrective action taken by the  
25 board until the requirements of section 806 are met.

1       “(b) MANDATORY TERMINATION.—In any case in  
2 which—

3           “(1) the applicable authority has been notified  
4 under subsection (a) (or by an issuer of excess/stop  
5 loss insurance or indemnity insurance pursuant to  
6 section 806(a)) of a failure of an association health  
7 plan which is or has been certified under this part  
8 and is described in section 806(a)(2) to meet the re-  
9 quirements of section 806 and has not been notified  
10 by the board of trustees of the plan that corrective  
11 action has restored compliance with such require-  
12 ments; and

13           “(2) the applicable authority determines that  
14 there is a reasonable expectation that the plan will  
15 continue to fail to meet the requirements of section  
16 806,

17 the board of trustees of the plan shall, at the direction  
18 of the applicable authority, terminate the plan and, in the  
19 course of the termination, take such actions as the appli-  
20 cable authority may require, including satisfying any  
21 claims referred to in section 806(a)(2)(B)(iii) and recov-  
22 ering for the plan any liability under subsection  
23 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
24 that the affairs of the plan will be, to the maximum extent

1 possible, wound up in a manner which will result in timely  
2 provision of all benefits for which the plan is obligated.

3 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
4 **VENT ASSOCIATION HEALTH PLANS PRO-**  
5 **VIDING HEALTH BENEFITS IN ADDITION TO**  
6 **HEALTH INSURANCE COVERAGE.**

7       “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
8 INSOLVENT PLANS.—Whenever the Secretary determines  
9 that an association health plan which is or has been cer-  
10 tified under this part and which is described in section  
11 806(a)(2) will be unable to provide benefits when due or  
12 is otherwise in a financially hazardous condition, as shall  
13 be defined by the Secretary by regulation, the Secretary  
14 shall, upon notice to the plan, apply to the appropriate  
15 United States district court for appointment of the Sec-  
16 retary as trustee to administer the plan for the duration  
17 of the insolvency. The plan may appear as a party and  
18 other interested persons may intervene in the proceedings  
19 at the discretion of the court. The court shall appoint such  
20 Secretary trustee if the court determines that the trustee-  
21 ship is necessary to protect the interests of the partici-  
22 pants and beneficiaries or providers of medical care or to  
23 avoid any unreasonable deterioration of the financial con-  
24 dition of the plan. The trusteeship of such Secretary shall  
25 continue until the conditions described in the first sen-

1 tence of this subsection are remedied or the plan is termi-  
2 nated.

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

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

9           “(2) to require the transfer of all (or any part)  
10 of the assets and records of the plan to the Sec-  
11 retary as trustee;

12           “(3) to invest any assets of the plan which the  
13 Secretary holds in accordance with the provisions of  
14 the plan, regulations prescribed by the Secretary,  
15 and applicable provisions of law;

16           “(4) to require the sponsor, the plan adminis-  
17 trator, any participating employer, and any employee  
18 organization representing plan participants to fur-  
19 nish any information with respect to the plan which  
20 the Secretary as trustee may reasonably need in  
21 order to administer the plan;

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

1           “(6) to commence, prosecute, or defend on be-  
2 half of the plan any suit or proceeding involving the  
3 plan;

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

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

13           “(9) to provide for the enrollment of plan par-  
14 ticipants and beneficiaries under appropriate cov-  
15 erage options; and

16           “(10) to do such other acts as may be nec-  
17 essary to comply with this title or any order of the  
18 court and to protect the interests of plan partici-  
19 pants and beneficiaries and providers of medical  
20 care.

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

24           “(1) the sponsor and plan administrator;

25           “(2) each participant;

1           “(3) each participating employer; and

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

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

12          “(e) OTHER PROCEEDINGS.—An application by the  
13          Secretary under this subsection may be filed notwith-  
14          standing the pendency in the same or any other court of  
15          any bankruptcy, mortgage foreclosure, or equity receiver-  
16          ship proceeding, or any proceeding to reorganize, conserve,  
17          or liquidate such plan or its property, or any proceeding  
18          to enforce a lien against property of the plan.

19          “(f) JURISDICTION OF COURT.—

20                 “(1) IN GENERAL.—Upon the filing of an appli-  
21                 cation for the appointment as trustee or the issuance  
22                 of a decree under this section, the court to which the  
23                 application is made shall have exclusive jurisdiction  
24                 of the plan involved and its property wherever lo-  
25                 cated with the powers, to the extent consistent with

1 the purposes of this section, of a court of the United  
2 States having jurisdiction over cases under chapter  
3 11 of title 11, United States Code. Pending an adju-  
4 dication under this section such court shall stay, and  
5 upon appointment by it of the Secretary as trustee,  
6 such court shall continue the stay of, any pending  
7 mortgage foreclosure, equity receivership, or other  
8 proceeding to reorganize, conserve, or liquidate the  
9 plan, the sponsor, or property of such plan or spon-  
10 sor, and any other suit against any receiver, conser-  
11 vator, or trustee of the plan, the sponsor, or prop-  
12 erty of the plan or sponsor. Pending such adjudica-  
13 tion and upon the appointment by it of the Sec-  
14 retary as trustee, the court may stay any proceeding  
15 to enforce a lien against property of the plan or the  
16 sponsor or any other suit against the plan or the  
17 sponsor.

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

1           “(g) PERSONNEL.—In accordance with regulations  
2 which shall be prescribed by the Secretary, the Secretary  
3 shall appoint, retain, and compensate accountants, actu-  
4 aries, and other professional service personnel as may be  
5 necessary in connection with the Secretary’s service as  
6 trustee under this section.

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

8           “(a) IN GENERAL.—Notwithstanding section 514, a  
9 State may impose by law a contribution tax on an associa-  
10 tion health plan described in section 806(a)(2), if the plan  
11 commenced operations in such State after the date of the  
12 enactment of the Small Business Health Fairness Act of  
13 2010.

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

18                   “(1) such tax is computed by applying a rate to  
19 the amount of premiums or contributions, with re-  
20 spect to individuals covered under the plan who are  
21 residents of such State, which are received by the  
22 plan from participating employers located in such  
23 State or from such individuals;

24                   “(2) the rate of such tax does not exceed the  
25 rate of any tax imposed by such State on premiums

1 or contributions received by insurers or health main-  
2 tenance organizations for health insurance coverage  
3 offered in such State in connection with a group  
4 health plan;

5 “(3) such tax is otherwise nondiscriminatory;  
6 and

7 “(4) the amount of any such tax assessed on  
8 the plan is reduced by the amount of any tax or as-  
9 sessment otherwise imposed by the State on pre-  
10 miums, contributions, or both received by insurers or  
11 health maintenance organizations for health insur-  
12 ance coverage, aggregate excess/stop loss insurance  
13 (as defined in section 806(g)(1)), specific excess/stop  
14 loss insurance (as defined in section 806(g)(2)),  
15 other insurance related to the provision of medical  
16 care under the plan, or any combination thereof pro-  
17 vided by such insurers or health maintenance organi-  
18 zations in such State in connection with such plan.

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

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

21 “(1) GROUP HEALTH PLAN.—The term ‘group  
22 health plan’ has the meaning provided in section  
23 733(a)(1) (after applying subsection (b) of this sec-  
24 tion).

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

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

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

9           “(5) APPLICABLE AUTHORITY.—The term ‘ap-  
10          pplicable authority’ means the Secretary, except that,  
11          in connection with any exercise of the Secretary’s  
12          authority regarding which the Secretary is required  
13          under section 506(d) to consult with a State, such  
14          term means the Secretary, in consultation with such  
15          State.

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

19          “(7) INDIVIDUAL MARKET.—

20                 “(A) IN GENERAL.—The term ‘individual  
21                 market’ means the market for health insurance  
22                 coverage offered to individuals other than in  
23                 connection with a group health plan.

24                 “(B) TREATMENT OF VERY SMALL  
25                 GROUPS.—

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

8                   “(ii) STATE EXCEPTION.—Clause (i)  
9                   shall not apply in the case of health insur-  
10                  ance coverage offered in a State if such  
11                  State regulates the coverage described in  
12                  such clause in the same manner and to the  
13                  same extent as coverage in the small group  
14                  market (as defined in section 2791(e)(5) of  
15                  the Public Health Service Act) is regulated  
16                  by such State.

17                  “(8) PARTICIPATING EMPLOYER.—The term  
18                  ‘participating employer’ means, in connection with  
19                  an association health plan, any employer, if any indi-  
20                  vidual who is an employee of such employer, a part-  
21                  ner in such employer, or a self-employed individual  
22                  who is such employer (or any dependent, as defined  
23                  under the terms of the plan, of such individual) is  
24                  or was covered under such plan in connection with  
25                  the status of such individual as such an employee,

1 partner, or self-employed individual in relation to the  
2 plan.

3 “(9) APPLICABLE STATE AUTHORITY.—The  
4 term ‘applicable State authority’ means, with respect  
5 to a health insurance issuer in a State, the State in-  
6 surance commissioner or official or officials des-  
7 ignated by the State to enforce the requirements of  
8 title XXVII of the Public Health Service Act for the  
9 State involved with respect to such issuer.

10 “(10) QUALIFIED ACTUARY.—The term ‘quali-  
11 fied actuary’ means an individual who is a member  
12 of the American Academy of Actuaries.

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

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

18 “(B) in the case of a sponsor with mem-  
19 bers which consist of associations, a person who  
20 is a member of any such association and elects  
21 an affiliated status with the sponsor, or

22 “(C) in the case of an association health  
23 plan in existence on the date of the enactment  
24 of the Small Business Health Fairness Act of

1           2010, a person eligible to be a member of the  
2           sponsor or one of its member associations.

3           “(12) LARGE EMPLOYER.—The term ‘large em-  
4           ployer’ means, in connection with a group health  
5           plan with respect to a plan year, an employer who  
6           employed an average of at least 51 employees on  
7           business days during the preceding calendar year  
8           and who employs at least 2 employees on the first  
9           day of the plan year.

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

14          “(b) RULES OF CONSTRUCTION.—

15                 “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
16                 poses of determining whether a plan, fund, or pro-  
17                 gram is an employee welfare benefit plan which is an  
18                 association health plan, and for purposes of applying  
19                 this title in connection with such plan, fund, or pro-  
20                 gram so determined to be such an employee welfare  
21                 benefit plan—

22                         “(A) in the case of a partnership, the term  
23                         ‘employer’ (as defined in section 3(5)) includes  
24                         the partnership in relation to the partners, and  
25                         the term ‘employee’ (as defined in section 3(6))

1 includes any partner in relation to the partner-  
2 ship; and

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

7 “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
8 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
9 case of any plan, fund, or program which was estab-  
10 lished or is maintained for the purpose of providing  
11 medical care (through the purchase of insurance or  
12 otherwise) for employees (or their dependents) cov-  
13 ered thereunder and which demonstrates to the Sec-  
14 retary that all requirements for certification under  
15 this part would be met with respect to such plan,  
16 fund, or program if such plan, fund, or program  
17 were a group health plan, such plan, fund, or pro-  
18 gram shall be treated for purposes of this title as an  
19 employee welfare benefit plan on and after the date  
20 of such demonstration.”.

21 (b) CONFORMING AMENDMENTS TO PREEMPTION  
22 RULES.—

23 (1) Section 514(b)(6) of such Act (29 U.S.C.  
24 1144(b)(6)) is amended by adding at the end the  
25 following new subparagraph:

1       “(E) The preceding subparagraphs of this paragraph  
2 do not apply with respect to any State law in the case  
3 of an association health plan which is certified under part  
4 8.”.

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

7           (A) in subsection (b)(4), by striking “Sub-  
8 section (a)” and inserting “Subsections (a) and  
9 (d)”;

10          (B) in subsection (b)(5), by striking “sub-  
11 section (a)” in subparagraph (A) and inserting  
12 “subsection (a) of this section and subsections  
13 (a)(2)(B) and (b) of section 805”, and by strik-  
14 ing “subsection (a)” in subparagraph (B) and  
15 inserting “subsection (a) of this section or sub-  
16 section (a)(2)(B) or (b) of section 805”;

17          (C) by redesignating subsection (d) as sub-  
18 section (e); and

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

21       “(d)(1) Except as provided in subsection (b)(4), the  
22 provisions of this title shall supersede any and all State  
23 laws insofar as they may now or hereafter preclude, or  
24 have the effect of precluding, a health insurance issuer  
25 from offering health insurance coverage in connection with

1 an association health plan which is certified under part  
2 8.

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

5 “(A) In any case in which health insurance cov-  
6 erage of any policy type is offered under an associa-  
7 tion health plan certified under part 8 to a partici-  
8 pating employer operating in such State, the provi-  
9 sions of this title shall supersede any and all laws  
10 of such State insofar as they may preclude a health  
11 insurance issuer from offering health insurance cov-  
12 erage of the same policy type to other employers op-  
13 erating in the State which are eligible for coverage  
14 under such association health plan, whether or not  
15 such other employers are participating employers in  
16 such plan.

17 “(B) In any case in which health insurance cov-  
18 erage of any policy type is offered in a State under  
19 an association health plan certified under part 8 and  
20 the filing, with the applicable State authority (as de-  
21 fined in section 812(a)(9)), of the policy form in  
22 connection with such policy type is approved by such  
23 State authority, the provisions of this title shall su-  
24 persede any and all laws of any other State in which  
25 health insurance coverage of such type is offered, in-

1       sofar as they may preclude, upon the filing in the  
2       same form and manner of such policy form with the  
3       applicable State authority in such other State, the  
4       approval of the filing in such other State.

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

9               “(A) providing solvency standards or similar  
10       standards regarding the adequacy of insurer capital,  
11       surplus, reserves, or contributions, or

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

13       “(4) For additional provisions relating to association  
14       health plans, see subsections (a)(2)(B) and (b) of section  
15       805.

16       “(5) For purposes of this subsection, the term ‘asso-  
17       ciation health plan’ has the meaning provided in section  
18       801(a), and the terms ‘health insurance coverage’, ‘par-  
19       ticipating employer’, and ‘health insurance issuer’ have  
20       the meanings provided such terms in section 812, respec-  
21       tively.”.

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

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

1 (B) in clause (ii), by inserting “and which  
2 does not provide medical care (within the mean-  
3 ing of section 733(a)(2)),” after “arrange-  
4 ment,”, and by striking “title.” and inserting  
5 “title, and”; and

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

8 “(iii) subject to subparagraph (E), in the case  
9 of any other employee welfare benefit plan which is  
10 a multiple employer welfare arrangement and which  
11 provides medical care (within the meaning of section  
12 733(a)(2)), any law of any State which regulates in-  
13 surance may apply.”.

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

16 (A) by striking “Nothing” and inserting  
17 “(1) Except as provided in paragraph (2), noth-  
18 ing”; and

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

21 “(2) Nothing in any other provision of law enacted  
22 on or after the date of the enactment of the Small Busi-  
23 ness Health Fairness Act of 2010 shall be construed to  
24 alter, amend, modify, invalidate, impair, or supersede any

1 provision of this title, except by specific cross-reference to  
2 the affected section.”.

3 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
4 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
5 the following new sentence: “Such term also includes a  
6 person serving as the sponsor of an association health plan  
7 under part 8.”.

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

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

19 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
20 CATION OF SELF-INSURED ASSOCIATION HEALTH  
21 PLANS.—Not later than January 1, 2012, the Secretary  
22 of Labor shall report to the Committee on Education and  
23 the Workforce of the House of Representatives and the  
24 Committee on Health, Education, Labor, and Pensions of

1 the Senate the effect association health plans have had,  
2 if any, on reducing the number of uninsured individuals.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

7 **SEC. 503. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
8 **LOYER ARRANGEMENTS.**

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

12 (1) in clause (i), by inserting after “control  
13 group,” the following: “except that, in any case in  
14 which the benefit referred to in subparagraph (A)  
15 consists of medical care (as defined in section  
16 812(a)(2)), two or more trades or businesses, wheth-  
17 er or not incorporated, shall be deemed a single em-

1        employer for any plan year of such plan, or any fiscal  
2        year of such other arrangement, if such trades or  
3        businesses are within the same control group during  
4        such year or at any time during the preceding 1-year  
5        period,”;

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

8            “(iii)(I) in any case in which the benefit re-  
9        ferred to in subparagraph (A) consists of medical  
10       care (as defined in section 812(a)(2)), the deter-  
11       mination of whether a trade or business is under  
12       ‘common control’ with another trade or business  
13       shall be determined under regulations of the Sec-  
14       retary applying principles consistent and coextensive  
15       with the principles applied in determining whether  
16       employees of two or more trades or businesses are  
17       treated as employed by a single employer under sec-  
18       tion 4001(b), except that, for purposes of this para-  
19       graph, an interest of greater than 25 percent may  
20       not be required as the minimum interest necessary  
21       for common control, or

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

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

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

3           “(iv) in any case in which the benefit referred  
4 to in subparagraph (A) consists of medical care (as  
5 defined in section 812(a)(2)), in determining, after  
6 the application of clause (i), whether benefits are  
7 provided to employees of two or more employers, the  
8 arrangement shall be treated as having only one par-  
9 ticipating employer if, after the application of clause  
10 (i), the number of individuals who are employees and  
11 former employees of any one participating employer  
12 and who are covered under the arrangement is  
13 greater than 75 percent of the aggregate number of  
14 all individuals who are employees or former employ-  
15 ees of participating employers and who are covered  
16 under the arrangement.”.

17 **SEC. 504. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
18 **CIATION HEALTH PLANS.**

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

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

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

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

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

9           “(2) having been established or maintained  
10 under or pursuant to one or more collective bar-  
11 gaining agreements which are reached pursuant to  
12 collective bargaining described in section 8(d) of the  
13 National Labor Relations Act (29 U.S.C. 158(d)) or  
14 paragraph Fourth of section 2 of the Railway Labor  
15 Act (45 U.S.C. 152, paragraph Fourth) or which are  
16 reached pursuant to labor-management negotiations  
17 under similar provisions of State public employee re-  
18 lations laws; or

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

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

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

4 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-  
5 SIST ORDERS.—

6 “(1) IN GENERAL.—Subject to paragraph (2),  
7 upon application by the Secretary showing the oper-  
8 ation, promotion, or marketing of an association  
9 health plan (or similar arrangement providing bene-  
10 fits consisting of medical care (as defined in section  
11 733(a)(2))) that—

12 “(A) is not certified under part 8, is sub-  
13 ject under section 514(b)(6) to the insurance  
14 laws of any State in which the plan or arrange-  
15 ment offers or provides benefits, and is not li-  
16 censed, registered, or otherwise approved under  
17 the insurance laws of such State; or

18 “(B) is an association health plan certified  
19 under part 8 and is not operating in accordance  
20 with the requirements under part 8 for such  
21 certification,

22 a district court of the United States shall enter an  
23 order requiring that the plan or arrangement cease  
24 activities.

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

5                   “(A) all benefits under it referred to in  
6           paragraph (1) consist of health insurance cov-  
7           erage; and

8                   “(B) with respect to each State in which  
9           the plan or arrangement offers or provides ben-  
10          efits, the plan or arrangement is operating in  
11          accordance with applicable State laws that are  
12          not superseded under section 514.

13           “(3) ADDITIONAL EQUITABLE RELIEF.—The  
14          court may grant such additional equitable relief, in-  
15          cluding any relief available under this title, as it  
16          deems necessary to protect the interests of the pub-  
17          lic and of persons having claims for benefits against  
18          the plan.”.

19          (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
20          Section 503 of such Act (29 U.S.C. 1133) is amended by  
21          inserting “(a) IN GENERAL.—” before “In accordance”,  
22          and by adding at the end the following new subsection:

23                   “(b) ASSOCIATION HEALTH PLANS.—The terms of  
24          each association health plan which is or has been certified  
25          under part 8 shall require the board of trustees or the

1 named fiduciary (as applicable) to ensure that the require-  
2 ments of this section are met in connection with claims  
3 filed under the plan.”.

4 **SEC. 505. COOPERATION BETWEEN FEDERAL AND STATE**  
5 **AUTHORITIES.**

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

9 “(d) CONSULTATION WITH STATES WITH RESPECT  
10 TO ASSOCIATION HEALTH PLANS.—

11 “(1) AGREEMENTS WITH STATES.—The Sec-  
12 retary shall consult with the State recognized under  
13 paragraph (2) with respect to an association health  
14 plan regarding the exercise of—

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

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

22 “(2) RECOGNITION OF PRIMARY DOMICILE  
23 STATE.—In carrying out paragraph (1), the Sec-  
24 retary shall ensure that only one State will be recog-  
25 nized, with respect to any particular association

1 health plan, as the State with which consultation is  
2 required. In carrying out this paragraph—

3 “(A) in the case of a plan which provides  
4 health insurance coverage (as defined in section  
5 812(a)(3)), such State shall be the State with  
6 which filing and approval of a policy type of-  
7 fered by the plan was initially obtained, and

8 “(B) in any other case, the Secretary shall  
9 take into account the places of residence of the  
10 participants and beneficiaries under the plan  
11 and the State in which the trust is main-  
12 tained.”.

13 **SEC. 506. EFFECTIVE DATE AND TRANSITIONAL AND**  
14 **OTHER RULES.**

15 (a) **EFFECTIVE DATE.**—The amendments made by  
16 this Act shall take effect 1 year after the date of the enact-  
17 ment of this Act. The Secretary of Labor shall first issue  
18 all regulations necessary to carry out the amendments  
19 made by this Act within 1 year after the date of the enact-  
20 ment of this Act.

21 (b) **TREATMENT OF CERTAIN EXISTING HEALTH**  
22 **BENEFITS PROGRAMS.**—

23 (1) **IN GENERAL.**—In any case in which, as of  
24 the date of the enactment of this Act, an arrange-  
25 ment is maintained in a State for the purpose of

1 providing benefits consisting of medical care for the  
2 employees and beneficiaries of its participating em-  
3 ployers, at least 200 participating employers make  
4 contributions to such arrangement, such arrange-  
5 ment has been in existence for at least 10 years, and  
6 such arrangement is licensed under the laws of one  
7 or more States to provide such benefits to its par-  
8 ticipating employers, upon the filing with the appli-  
9 cable authority (as defined in section 812(a)(5) of  
10 the Employee Retirement Income Security Act of  
11 1974 (as amended by this subtitle)) by the arrange-  
12 ment of an application for certification of the ar-  
13 rangement under part 8 of subtitle B of title I of  
14 such Act—

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

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

22 (C) the requirements of section 803(b) of  
23 such Act shall be deemed met, if the arrange-  
24 ment is operated by a board of directors  
25 which—

1 (i) is elected by the participating em-  
2 ployers, with each employer having one  
3 vote; and

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

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

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

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

19 (2) DEFINITIONS.—For purposes of this sub-  
20 section, the terms “group health plan”, “medical  
21 care”, and “participating employer” shall have the  
22 meanings provided in section 812 of the Employee  
23 Retirement Income Security Act of 1974, except  
24 that the reference in paragraph (7) of such section  
25 to an “association health plan” shall be deemed a

- 1 reference to an arrangement referred to in this sub-
- 2 section.

