

108<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

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# H. R. 4279

## AN ACT

To amend the Internal Revenue Code of 1986 to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, and to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees.



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

1 **SECTION 1. TABLE OF CONTENTS.**

2 The table of contents for this Act is as follows:

Sec. 1. Table of contents.

Sec. 2. Disposition of unused health benefits in cafeteria plans and flexible spending arrangements.

TITLE I—HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY  
HEALTHCARE (HEALTH) ACT OF 2004

Sec. 1001. Short title.

Sec. 1002. Findings and purpose.

Sec. 1003. Encouraging speedy resolution of claims.

Sec. 1004. Compensating patient injury.

Sec. 1005. Maximizing patient recovery.

Sec. 1006. Additional health benefits.

Sec. 1007. Punitive damages.

Sec. 1008. Authorization of payment of future damages to claimants in health care lawsuits.

Sec. 1009. Definitions.

Sec. 1010. Effect on other laws.

Sec. 1011. State flexibility and protection of States' rights.

Sec. 1012. Applicability; effective date.

Sec. 1013. Sense of Congress.

TITLE II—SMALL BUSINESS HEALTH FAIRNESS ACT OF 2004

Sec. 2001. Short title.

Sec. 2002. Rules governing association health plans.

Sec. 2003. Clarification of treatment of single employer arrangements.

Sec. 2004. Enforcement provisions relating to association health plans.

Sec. 2005. Cooperation between Federal and State authorities.

Sec. 2006. Effective date and transitional and other rules.

3 **SEC. 2. DISPOSITION OF UNUSED HEALTH BENEFITS IN**  
4 **CAFETERIA PLANS AND FLEXIBLE SPENDING**  
5 **ARRANGEMENTS.**

6 (a) IN GENERAL.—Section 125 of the Internal Rev-  
7 enue Code of 1986 (relating to cafeteria plans) is amended  
8 by redesignating subsections (h) and (i) as subsections (i)  
9 and (j), respectively, and by inserting after subsection (g)  
10 the following:

11 “(h) CONTRIBUTIONS OF CERTAIN UNUSED HEALTH  
12 BENEFITS.—

1           “(1) IN GENERAL.—For purposes of this title,  
2 a plan or other arrangement shall not fail to be  
3 treated as a cafeteria plan solely because qualified  
4 benefits under such plan include a health flexible  
5 spending arrangement under which not more than  
6 \$500 of unused health benefits may be—

7           “(A) carried forward to the succeeding  
8 plan year of such health flexible spending ar-  
9 rangement, or

10           “(B) to the extent permitted by section  
11 106(d), contributed by the employer to a health  
12 savings account (as defined in section 223(d))  
13 maintained for the benefit of the employee.

14           “(2) HEALTH FLEXIBLE SPENDING ARRANGE-  
15 MENT.—For purposes of this subsection, the term  
16 ‘health flexible spending arrangement’ means a flexi-  
17 ble spending arrangement (as defined in section  
18 106(c)) that is a qualified benefit and only permits  
19 reimbursement for expenses for medical care (as de-  
20 fined in section 213(d)(1), without regard to sub-  
21 paragraphs (C) and (D) thereof).

22           “(3) UNUSED HEALTH BENEFITS.—For pur-  
23 poses of this subsection, with respect to an em-  
24 ployee, the term ‘unused health benefits’ means the  
25 excess of—

1           “(A) the maximum amount of reimburse-  
2           ment allowable to the employee for a plan year  
3           under a health flexible spending arrangement,  
4           over

5           “(B) the actual amount of reimbursement  
6           for such year under such arrangement.”.

7           (b) EFFECTIVE DATE.—The amendments made by  
8           subsection (a) shall apply to taxable years beginning after  
9           December 31, 2003.

10 **TITLE I—HELP EFFICIENT, AC-**  
11 **CESSIBLE, LOW-COST, TIMELY**  
12 **HEALTHCARE (HEALTH) ACT**  
13 **OF 2004**

14 **SEC. 1001. SHORT TITLE.**

15           This title may be cited as the “Help Efficient, Acces-  
16           sible, Low-cost, Timely Healthcare (HEALTH) Act of  
17           2004”.

18 **SEC. 1002. FINDINGS AND PURPOSE.**

19           (a) FINDINGS.—

20           (1) EFFECT ON HEALTH CARE ACCESS AND  
21           COSTS.—Congress finds that our current civil justice  
22           system is adversely affecting patient access to health  
23           care services, better patient care, and cost-efficient  
24           health care, in that the health care liability system  
25           is a costly and ineffective mechanism for resolving

1 claims of health care liability and compensating in-  
2 jured patients, and is a deterrent to the sharing of  
3 information among health care professionals which  
4 impedes efforts to improve patient safety and quality  
5 of care.

6 (2) EFFECT ON INTERSTATE COMMERCE.—

7 Congress finds that the health care and insurance  
8 industries are industries affecting interstate com-  
9 merce and the health care liability litigation systems  
10 existing throughout the United States are activities  
11 that affect interstate commerce by contributing to  
12 the high costs of health care and premiums for  
13 health care liability insurance purchased by health  
14 care system providers.

15 (3) EFFECT ON FEDERAL SPENDING.—Con-

16 gress finds that the health care liability litigation  
17 systems existing throughout the United States have  
18 a significant effect on the amount, distribution, and  
19 use of Federal funds because of—

20 (A) the large number of individuals who

21 receive health care benefits under programs op-  
22 erated or financed by the Federal Government;

23 (B) the large number of individuals who

24 benefit because of the exclusion from Federal

1           taxes of the amounts spent to provide them  
2           with health insurance benefits; and

3                   (C) the large number of health care pro-  
4           viders who provide items or services for which  
5           the Federal Government makes payments.

6           (b) PURPOSE.—It is the purpose of this Act to imple-  
7           ment reasonable, comprehensive, and effective health care  
8           liability reforms designed to—

9                   (1) improve the availability of health care serv-  
10          ices in cases in which health care liability actions  
11          have been shown to be a factor in the decreased  
12          availability of services;

13                   (2) reduce the incidence of “defensive medi-  
14          cine” and lower the cost of health care liability in-  
15          surance, all of which contribute to the escalation of  
16          health care costs;

17                   (3) ensure that persons with meritorious health  
18          care injury claims receive fair and adequate com-  
19          pensation, including reasonable noneconomic dam-  
20          ages;

21                   (4) improve the fairness and cost-effectiveness  
22          of our current health care liability system to resolve  
23          disputes over, and provide compensation for, health  
24          care liability by reducing uncertainty in the amount  
25          of compensation provided to injured individuals; and

1           (5) provide an increased sharing of information  
2           in the health care system which will reduce unin-  
3           tended injury and improve patient care.

4 **SEC. 1003. ENCOURAGING SPEEDY RESOLUTION OF**  
5           **CLAIMS.**

6           The time for the commencement of a health care law-  
7           suit shall be 3 years after the date of manifestation of  
8           injury or 1 year after the claimant discovers, or through  
9           the use of reasonable diligence should have discovered, the  
10          injury, whichever occurs first. In no event shall the time  
11          for commencement of a health care lawsuit exceed 3 years  
12          after the date of manifestation of injury unless tolled for  
13          any of the following—

14                 (1) upon proof of fraud;

15                 (2) intentional concealment; or

16                 (3) the presence of a foreign body, which has no  
17          therapeutic or diagnostic purpose or effect, in the  
18          person of the injured person.

19          Actions by a minor shall be commenced within 3 years  
20          from the date of the alleged manifestation of injury except  
21          that actions by a minor under the full age of 6 years shall  
22          be commenced within 3 years of manifestation of injury  
23          or prior to the minor's 8th birthday, whichever provides  
24          a longer period. Such time limitation shall be tolled for  
25          minors for any period during which a parent or guardian

1 and a health care provider or health care organization  
2 have committed fraud or collusion in the failure to bring  
3 an action on behalf of the injured minor.

4 **SEC. 1004. COMPENSATING PATIENT INJURY.**

5 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL  
6 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any  
7 health care lawsuit, nothing in this title shall limit a claim-  
8 ant’s recovery of the full amount of the available economic  
9 damages, notwithstanding the limitation in subsection (b).

10 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any  
11 health care lawsuit, the amount of noneconomic damages,  
12 if available, may be as much as \$250,000, regardless of  
13 the number of parties against whom the action is brought  
14 or the number of separate claims or actions brought with  
15 respect to the same injury.

16 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC  
17 DAMAGES.—For purposes of applying the limitation in  
18 subsection (b), future noneconomic damages shall not be  
19 discounted to present value. The jury shall not be in-  
20 formed about the maximum award for noneconomic dam-  
21 ages. An award for noneconomic damages in excess of  
22 \$250,000 shall be reduced either before the entry of judg-  
23 ment, or by amendment of the judgment after entry of  
24 judgment, and such reduction shall be made before ac-  
25 counting for any other reduction in damages required by

1 law. If separate awards are rendered for past and future  
2 noneconomic damages and the combined awards exceed  
3 \$250,000, the future noneconomic damages shall be re-  
4 duced first.

5 (d) FAIR SHARE RULE.—In any health care lawsuit,  
6 each party shall be liable for that party’s several share  
7 of any damages only and not for the share of any other  
8 person. Each party shall be liable only for the amount of  
9 damages allocated to such party in direct proportion to  
10 such party’s percentage of responsibility. Whenever a  
11 judgment of liability is rendered as to any party, a sepa-  
12 rate judgment shall be rendered against each such party  
13 for the amount allocated to such party. For purposes of  
14 this section, the trier of fact shall determine the propor-  
15 tion of responsibility of each party for the claimant’s  
16 harm.

17 **SEC. 1005. MAXIMIZING PATIENT RECOVERY.**

18 (a) COURT SUPERVISION OF SHARE OF DAMAGES  
19 ACTUALLY PAID TO CLAIMANTS.—In any health care law-  
20 suit, the court shall supervise the arrangements for pay-  
21 ment of damages to protect against conflicts of interest  
22 that may have the effect of reducing the amount of dam-  
23 ages awarded that are actually paid to claimants. In par-  
24 ticular, in any health care lawsuit in which the attorney  
25 for a party claims a financial stake in the outcome by vir-

1 tue of a contingent fee, the court shall have the power  
2 to restrict the payment of a claimant's damage recovery  
3 to such attorney, and to redirect such damages to the  
4 claimant based upon the interests of justice and principles  
5 of equity. In no event shall the total of all contingent fees  
6 for representing all claimants in a health care lawsuit ex-  
7 ceed the following limits:

8 (1) 40 percent of the first \$50,000 recovered by  
9 the claimant(s).

10 (2)  $33\frac{1}{3}$  percent of the next \$50,000 recovered  
11 by the claimant(s).

12 (3) 25 percent of the next \$500,000 recovered  
13 by the claimant(s).

14 (4) 15 percent of any amount by which the re-  
15 covery by the claimant(s) is in excess of \$600,000.

16 (b) APPLICABILITY.—The limitations in this section  
17 shall apply whether the recovery is by judgment, settle-  
18 ment, mediation, arbitration, or any other form of alter-  
19 native dispute resolution. In a health care lawsuit involv-  
20 ing a minor or incompetent person, a court retains the  
21 authority to authorize or approve a fee that is less than  
22 the maximum permitted under this section. The require-  
23 ment for court supervision in the first two sentences of  
24 subsection (a) applies only in civil actions.

1 **SEC. 1006. ADDITIONAL HEALTH BENEFITS.**

2       In any health care lawsuit involving injury or wrong-  
3 ful death, any party may introduce evidence of collateral  
4 source benefits. If a party elects to introduce such evi-  
5 dence, any opposing party may introduce evidence of any  
6 amount paid or contributed or reasonably likely to be paid  
7 or contributed in the future by or on behalf of the oppos-  
8 ing party to secure the right to such collateral source bene-  
9 fits. No provider of collateral source benefits shall recover  
10 any amount against the claimant or receive any lien or  
11 credit against the claimant's recovery or be equitably or  
12 legally subrogated to the right of the claimant in a health  
13 care lawsuit involving injury or wrongful death. This sec-  
14 tion shall apply to any health care lawsuit that is settled  
15 as well as a health care lawsuit that is resolved by a fact  
16 finder. This section shall not apply to section 1862(b) (42  
17 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.  
18 1396a(a)(25)) of the Social Security Act.

19 **SEC. 1007. PUNITIVE DAMAGES.**

20       (a) IN GENERAL.—Punitive damages may, if other-  
21 wise permitted by applicable State or Federal law, be  
22 awarded against any person in a health care lawsuit only  
23 if it is proven by clear and convincing evidence that such  
24 person acted with malicious intent to injure the claimant,  
25 or that such person deliberately failed to avoid unneces-  
26 sary injury that such person knew the claimant was sub-

1 stantially certain to suffer. In any health care lawsuit  
2 where no judgment for compensatory damages is rendered  
3 against such person, no punitive damages may be awarded  
4 with respect to the claim in such lawsuit. No demand for  
5 punitive damages shall be included in a health care lawsuit  
6 as initially filed. A court may allow a claimant to file an  
7 amended pleading for punitive damages only upon a mo-  
8 tion by the claimant and after a finding by the court, upon  
9 review of supporting and opposing affidavits or after a  
10 hearing, after weighing the evidence, that the claimant has  
11 established by a substantial probability that the claimant  
12 will prevail on the claim for punitive damages. At the re-  
13 quest of any party in a health care lawsuit, the trier of  
14 fact shall consider in a separate proceeding—

15           (1) whether punitive damages are to be award-  
16           ed and the amount of such award; and

17           (2) the amount of punitive damages following a  
18           determination of punitive liability.

19 If a separate proceeding is requested, evidence relevant  
20 only to the claim for punitive damages, as determined by  
21 applicable State law, shall be inadmissible in any pro-  
22 ceeding to determine whether compensatory damages are  
23 to be awarded.

24           (b) DETERMINING AMOUNT OF PUNITIVE DAM-  
25 AGES.—

1           (1) FACTORS CONSIDERED.—In determining  
2 the amount of punitive damages, if awarded, in a  
3 health care lawsuit, the trier of fact shall consider  
4 only the following—

5                   (A) the severity of the harm caused by the  
6 conduct of such party;

7                   (B) the duration of the conduct or any  
8 concealment of it by such party;

9                   (C) the profitability of the conduct to such  
10 party;

11                   (D) the number of products sold or med-  
12 ical procedures rendered for compensation, as  
13 the case may be, by such party, of the kind  
14 causing the harm complained of by the claim-  
15 ant;

16                   (E) any criminal penalties imposed on such  
17 party, as a result of the conduct complained of  
18 by the claimant; and

19                   (F) the amount of any civil fines assessed  
20 against such party as a result of the conduct  
21 complained of by the claimant.

22           (2) MAXIMUM AWARD.—The amount of punitive  
23 damages, if awarded, in a health care lawsuit may  
24 be as much as \$250,000 or as much as two times  
25 the amount of economic damages awarded, which-

1 ever is greater. The jury shall not be informed of  
2 this limitation.

3 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT  
4 COMPLY WITH FDA STANDARDS.—

5 (1) IN GENERAL.—

6 (A) No punitive damages may be awarded  
7 against the manufacturer or distributor of a  
8 medical product, or a supplier of any compo-  
9 nent or raw material of such medical product,  
10 based on a claim that such product caused the  
11 claimant's harm where—

12 (i)(I) such medical product was sub-  
13 ject to premarket approval, clearance, or li-  
14 censure by the Food and Drug Administra-  
15 tion with respect to the safety of the for-  
16 mulation or performance of the aspect of  
17 such medical product which caused the  
18 claimant's harm or the adequacy of the  
19 packaging or labeling of such medical  
20 product; and

21 (II) such medical product was so ap-  
22 proved, cleared, or licensed; or

23 (ii) such medical product is generally  
24 recognized among qualified experts as safe  
25 and effective pursuant to conditions estab-

1           lished by the Food and Drug Administra-  
2           tion and applicable Food and Drug Admin-  
3           istration regulations, including without  
4           limitation those related to packaging and  
5           labeling, unless the Food and Drug Admin-  
6           istration has determined that such medical  
7           product was not manufactured or distrib-  
8           uted in substantial compliance with appli-  
9           cable Food and Drug Administration stat-  
10          utes and regulations.

11           (B) RULE OF CONSTRUCTION.—Subpara-  
12          graph (A) may not be construed as establishing  
13          the obligation of the Food and Drug Adminis-  
14          tration to demonstrate affirmatively that a  
15          manufacturer, distributor, or supplier referred  
16          to in such subparagraph meets any of the con-  
17          ditions described in such subparagraph.

18           (2) LIABILITY OF HEALTH CARE PROVIDERS.—  
19          A health care provider who prescribes, or who dis-  
20          penses pursuant to a prescription, a medical product  
21          approved, licensed, or cleared by the Food and Drug  
22          Administration shall not be named as a party to a  
23          product liability lawsuit involving such product and  
24          shall not be liable to a claimant in a class action  
25          lawsuit against the manufacturer, distributor, or

1 seller of such product. Nothing in this paragraph  
2 prevents a court from consolidating cases involving  
3 health care providers and cases involving products li-  
4 ability claims against the manufacturer, distributor,  
5 or product seller of such medical product.

6 (3) PACKAGING.—In a health care lawsuit for  
7 harm which is alleged to relate to the adequacy of  
8 the packaging or labeling of a drug which is required  
9 to have tamper-resistant packaging under regula-  
10 tions of the Secretary of Health and Human Serv-  
11 ices (including labeling regulations related to such  
12 packaging), the manufacturer or product seller of  
13 the drug shall not be held liable for punitive dam-  
14 ages unless such packaging or labeling is found by  
15 the trier of fact by clear and convincing evidence to  
16 be substantially out of compliance with such regula-  
17 tions.

18 (4) EXCEPTION.—Paragraph (1) shall not  
19 apply in any health care lawsuit in which—

20 (A) a person, before or after premarket ap-  
21 proval, clearance, or licensure of such medical  
22 product, knowingly misrepresented to or with-  
23 held from the Food and Drug Administration  
24 information that is required to be submitted  
25 under the Federal Food, Drug, and Cosmetic

1 Act (21 U.S.C. 301 et seq.) or section 351 of  
2 the Public Health Service Act (42 U.S.C. 262)  
3 that is material and is causally related to the  
4 harm which the claimant allegedly suffered; or

5 (B) a person made an illegal payment to  
6 an official of the Food and Drug Administra-  
7 tion for the purpose of either securing or main-  
8 taining approval, clearance, or licensure of such  
9 medical product.

10 **SEC. 1008. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**  
11 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**  
12 **SUITS.**

13 (a) IN GENERAL.—In any health care lawsuit, if an  
14 award of future damages, without reduction to present  
15 value, equaling or exceeding \$50,000 is made against a  
16 party with sufficient insurance or other assets to fund a  
17 periodic payment of such a judgment, the court shall, at  
18 the request of any party, enter a judgment ordering that  
19 the future damages be paid by periodic payments. In any  
20 health care lawsuit, the court may be guided by the Uni-  
21 form Periodic Payment of Judgments Act promulgated by  
22 the National Conference of Commissioners on Uniform  
23 State Laws.

1 (b) APPLICABILITY.—This section applies to all ac-  
2 tions that have not been first set for trial or retrial before  
3 the effective date of this title.

4 **SEC. 1009. DEFINITIONS.**

5 In this title:

6 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
7 TEM; ADR.—The term “alternative dispute resolution  
8 system” or “ADR” means a system that provides  
9 for the resolution of health care lawsuits in a man-  
10 ner other than through a civil action brought in a  
11 State or Federal court.

12 (2) CLAIMANT.—The term “claimant” means  
13 any person who brings a health care lawsuit, includ-  
14 ing a person who asserts or claims a right to legal  
15 or equitable contribution, indemnity or subrogation,  
16 arising out of a health care liability claim or action,  
17 and any person on whose behalf such a claim is as-  
18 serted or such an action is brought, whether de-  
19 ceased, incompetent, or a minor.

20 (3) COLLATERAL SOURCE BENEFITS.—The  
21 term “collateral source benefits” means any amount  
22 paid or reasonably likely to be paid in the future to  
23 or on behalf of the claimant, or any service, product  
24 or other benefit provided or reasonably likely to be  
25 provided in the future to or on behalf of the claim-

1 ant, as a result of the injury or wrongful death, pur-  
2 suant to—

3 (A) any State or Federal health, sickness,  
4 income-disability, accident, or workers' com-  
5 pensation law;

6 (B) any health, sickness, income-disability,  
7 or accident insurance that provides health bene-  
8 fits or income-disability coverage;

9 (C) any contract or agreement of any  
10 group, organization, partnership, or corporation  
11 to provide, pay for, or reimburse the cost of  
12 medical, hospital, dental, or income disability  
13 benefits; and

14 (D) any other publicly or privately funded  
15 program.

16 (4) COMPENSATORY DAMAGES.—The term  
17 “compensatory damages” means objectively  
18 verifiable monetary losses incurred as a result of the  
19 provision of, use of, or payment for (or failure to  
20 provide, use, or pay for) health care services or med-  
21 ical products, such as past and future medical ex-  
22 penses, loss of past and future earnings, cost of ob-  
23 taining domestic services, loss of employment, and  
24 loss of business or employment opportunities, dam-  
25 ages for physical and emotional pain, suffering, in-

1 convenience, physical impairment, mental anguish,  
2 disfigurement, loss of enjoyment of life, loss of soci-  
3 ety and companionship, loss of consortium (other  
4 than loss of domestic service), hedonic damages, in-  
5 jury to reputation, and all other nonpecuniary losses  
6 of any kind or nature. The term “compensatory  
7 damages” includes economic damages and non-  
8 economic damages, as such terms are defined in this  
9 section.

10 (5) CONTINGENT FEE.—The term “contingent  
11 fee” includes all compensation to any person or per-  
12 sons which is payable only if a recovery is effected  
13 on behalf of one or more claimants.

14 (6) ECONOMIC DAMAGES.—The term “economic  
15 damages” means objectively verifiable monetary  
16 losses incurred as a result of the provision of, use  
17 of, or payment for (or failure to provide, use, or pay  
18 for) health care services or medical products, such as  
19 past and future medical expenses, loss of past and  
20 future earnings, cost of obtaining domestic services,  
21 loss of employment, and loss of business or employ-  
22 ment opportunities.

23 (7) HEALTH CARE LAWSUIT.—The term  
24 “health care lawsuit” means any health care liability  
25 claim concerning the provision of health care goods

1 or services or any medical product affecting inter-  
2 state commerce, or any health care liability action  
3 concerning the provision of health care goods or  
4 services or any medical product affecting interstate  
5 commerce, brought in a State or Federal court or  
6 pursuant to an alternative dispute resolution system,  
7 against a health care provider, a health care organi-  
8 zation, or the manufacturer, distributor, supplier,  
9 marketer, promoter, or seller of a medical product,  
10 regardless of the theory of liability on which the  
11 claim is based, or the number of claimants, plain-  
12 tiffs, defendants, or other parties, or the number of  
13 claims or causes of action, in which the claimant al-  
14 leges a health care liability claim. Such term does  
15 not include a claim or action which is based on  
16 criminal liability; which seeks civil fines or penalties  
17 paid to Federal, State, or local government; or which  
18 is grounded in antitrust.

19 (8) HEALTH CARE LIABILITY ACTION.—The  
20 term “health care liability action” means a civil ac-  
21 tion brought in a State or Federal Court or pursu-  
22 ant to an alternative dispute resolution system,  
23 against a health care provider, a health care organi-  
24 zation, or the manufacturer, distributor, supplier,  
25 marketer, promoter, or seller of a medical product,

1       regardless of the theory of liability on which the  
2       claim is based, or the number of plaintiffs, defend-  
3       ants, or other parties, or the number of causes of ac-  
4       tion, in which the claimant alleges a health care li-  
5       ability claim.

6               (9) HEALTH CARE LIABILITY CLAIM.—The  
7       term “health care liability claim” means a demand  
8       by any person, whether or not pursuant to ADR,  
9       against a health care provider, health care organiza-  
10      tion, or the manufacturer, distributor, supplier, mar-  
11      keter, promoter, or seller of a medical product, in-  
12      cluding, but not limited to, third-party claims, cross-  
13      claims, counter-claims, or contribution claims, which  
14      are based upon the provision of, use of, or payment  
15      for (or the failure to provide, use, or pay for) health  
16      care services or medical products, regardless of the  
17      theory of liability on which the claim is based, or the  
18      number of plaintiffs, defendants, or other parties, or  
19      the number of causes of action.

20              (10) HEALTH CARE ORGANIZATION.—The term  
21      “health care organization” means any person or en-  
22      tity which is obligated to provide or pay for health  
23      benefits under any health plan, including any person  
24      or entity acting under a contract or arrangement

1 with a health care organization to provide or admin-  
2 ister any health benefit.

3 (11) HEALTH CARE PROVIDER.—The term  
4 “health care provider” means any person or entity  
5 required by State or Federal laws or regulations to  
6 be licensed, registered, or certified to provide health  
7 care services, and being either so licensed, reg-  
8 istered, or certified, or exempted from such require-  
9 ment by other statute or regulation.

10 (12) HEALTH CARE GOODS OR SERVICES.—The  
11 term “health care goods or services” means any  
12 goods or services provided by a health care organiza-  
13 tion, provider, or by any individual working under  
14 the supervision of a health care provider, that relates  
15 to the diagnosis, prevention, or treatment of any  
16 human disease or impairment, or the assessment or  
17 care of the health of human beings.

18 (13) MALICIOUS INTENT TO INJURE.—The  
19 term “malicious intent to injure” means inten-  
20 tionally causing or attempting to cause physical in-  
21 jury other than providing health care goods or serv-  
22 ices.

23 (14) MEDICAL PRODUCT.—The term “medical  
24 product” means a drug, device, or biological product  
25 intended for humans, and the terms “drug”, “de-

1 vice”, and “biological product” have the meanings  
2 given such terms in sections 201(g)(1) and 201(h)  
3 of the Federal Food, Drug and Cosmetic Act (21  
4 U.S.C. 321) and section 351(a) of the Public Health  
5 Service Act (42 U.S.C. 262(a)), respectively, includ-  
6 ing any component or raw material used therein, but  
7 excluding health care services.

8 (15) NONECONOMIC DAMAGES.—The term  
9 “noneconomic damages” means damages for phys-  
10 ical and emotional pain, suffering, inconvenience,  
11 physical impairment, mental anguish, disfigurement,  
12 loss of enjoyment of life, loss of society and compan-  
13 ionship, loss of consortium (other than loss of do-  
14 mestic service), hedonic damages, injury to reputa-  
15 tion, and all other nonpecuniary losses of any kind  
16 or nature.

17 (16) PUNITIVE DAMAGES.—The term “punitive  
18 damages” means damages awarded, for the purpose  
19 of punishment or deterrence, and not solely for com-  
20 pensatory purposes, against a health care provider,  
21 health care organization, or a manufacturer, dis-  
22 tributor, or supplier of a medical product. Punitive  
23 damages are neither economic nor noneconomic  
24 damages.

1           (17) RECOVERY.—The term “recovery” means  
2           the net sum recovered after deducting any disburse-  
3           ments or costs incurred in connection with prosecu-  
4           tion or settlement of the claim, including all costs  
5           paid or advanced by any person. Costs of health care  
6           incurred by the plaintiff and the attorneys’ office  
7           overhead costs or charges for legal services are not  
8           deductible disbursements or costs for such purpose.

9           (18) STATE.—The term “State” means each of  
10          the several States, the District of Columbia, the  
11          Commonwealth of Puerto Rico, the Virgin Islands,  
12          Guam, American Samoa, the Northern Mariana Is-  
13          lands, the Trust Territory of the Pacific Islands, and  
14          any other territory or possession of the United  
15          States, or any political subdivision thereof.

16 **SEC. 1010. EFFECT ON OTHER LAWS.**

17          (a) VACCINE INJURY.—

18               (1) To the extent that title XXI of the Public  
19               Health Service Act establishes a Federal rule of law  
20               applicable to a civil action brought for a vaccine-re-  
21               lated injury or death—

22                       (A) this title does not affect the application  
23                       of the rule of law to such an action; and

1 (B) any rule of law prescribed by this title  
2 in conflict with a rule of law of such title XXI  
3 shall not apply to such action.

4 (2) If there is an aspect of a civil action  
5 brought for a vaccine-related injury or death to  
6 which a Federal rule of law under title XXI of the  
7 Public Health Service Act does not apply, then this  
8 title or otherwise applicable law (as determined  
9 under this title) will apply to such aspect of such ac-  
10 tion.

11 (b) OTHER FEDERAL LAW.—Except as provided in  
12 this section, nothing in this title shall be deemed to affect  
13 any defense available to a defendant in a health care law-  
14 suit or action under any other provision of Federal law.

15 **SEC. 1011. STATE FLEXIBILITY AND PROTECTION OF**  
16 **STATES' RIGHTS.**

17 (a) HEALTH CARE LAWSUITS.—The provisions gov-  
18 erning health care lawsuits set forth in this title preempt,  
19 subject to subsections (b) and (c), State law to the extent  
20 that State law prevents the application of any provisions  
21 of law established by or under this title. The provisions  
22 governing health care lawsuits set forth in this title super-  
23 sede chapter 171 of title 28, United States Code, to the  
24 extent that such chapter—

1           (1) provides for a greater amount of damages  
2           or contingent fees, a longer period in which a health  
3           care lawsuit may be commenced, or a reduced appli-  
4           cability or scope of periodic payment of future dam-  
5           ages, than provided in this title; or

6           (2) prohibits the introduction of evidence re-  
7           garding collateral source benefits, or mandates or  
8           permits subrogation or a lien on collateral source  
9           benefits.

10          (b) PROTECTION OF STATES' RIGHTS AND OTHER  
11 LAWS.—(1) Any issue that is not governed by any provi-  
12 sion of law established by or under this title (including  
13 State standards of negligence) shall be governed by other-  
14 wise applicable State or Federal law.

15          (2) This title shall not preempt or supersede any  
16 State or Federal law that imposes greater procedural or  
17 substantive protections for health care providers and  
18 health care organizations from liability, loss, or damages  
19 than those provided by this title or create a cause of ac-  
20 tion.

21          (c) STATE FLEXIBILITY.—No provision of this title  
22 shall be construed to preempt—

23               (1) any State law (whether effective before, on,  
24               or after the date of the enactment of this title) that  
25               specifies a particular monetary amount of compen-

1 satory or punitive damages (or the total amount of  
2 damages) that may be awarded in a health care law-  
3 suit, regardless of whether such monetary amount is  
4 greater or lesser than is provided for under this title,  
5 notwithstanding section 4(a); or

6 (2) any defense available to a party in a health  
7 care lawsuit under any other provision of State or  
8 Federal law.

9 **SEC. 1012. APPLICABILITY; EFFECTIVE DATE.**

10 This title shall apply to any health care lawsuit  
11 brought in a Federal or State court, or subject to an alter-  
12 native dispute resolution system, that is initiated on or  
13 after the date of the enactment of this title, except that  
14 any health care lawsuit arising from an injury occurring  
15 prior to the date of the enactment of this title shall be  
16 governed by the applicable statute of limitations provisions  
17 in effect at the time the injury occurred.

18 **SEC. 1013. SENSE OF CONGRESS.**

19 It is the sense of Congress that a health insurer  
20 should be liable for damages for harm caused when it  
21 makes a decision as to what care is medically necessary  
22 and appropriate.

1           **TITLE II—SMALL BUSINESS**  
2           **HEALTH FAIRNESS ACT OF 2004**

3   **SEC. 2001. SHORT TITLE.**

4           This title may be cited as the “Small Business Health  
5   Fairness Act of 2004”.

6   **SEC. 2002. RULES GOVERNING ASSOCIATION HEALTH**  
7   **PLANS.**

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

11           **“PART 8—RULES GOVERNING ASSOCIATION**  
12   **HEALTH PLANS**

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

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

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

20                   “(1) is organized and maintained in good faith,  
21           with a constitution and bylaws specifically stating its  
22           purpose and providing for periodic meetings on at  
23           least an annual basis, as a bona fide trade associa-  
24           tion, a bona fide industry association (including a  
25           rural electric cooperative association or a rural tele-

1 phone cooperative association), a bona fide profes-  
2 sional association, or a bona fide chamber of com-  
3 merce (or similar bona fide business association, in-  
4 cluding a corporation or similar organization that  
5 operates on a cooperative basis (within the meaning  
6 of section 1381 of the Internal Revenue Code of  
7 1986)), for substantial purposes other than that of  
8 obtaining or providing medical care;

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

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

21 Any sponsor consisting of an association of entities which  
22 meet the requirements of paragraphs (1), (2), and (3)  
23 shall be deemed to be a sponsor described in this sub-  
24 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 2004,

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;  
7 foodservice 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 2004.

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 2004, 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  
18 with an attachment point which is not  
19 greater than 125 percent of expected gross  
20 annual claims. The applicable authority  
21 may by regulation provide for upward ad-  
22 justments in the amount of such percent-  
23 age in specified circumstances in which the  
24 plan specifically provides for and maintains

1 reserves 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 commend, 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 in-  
13 surance 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 insur-  
22 ance, and indemnification insurance as the applicable au-  
23 thority considers appropriate. Such requirements may be  
24 provided by regulation with respect to any such plan or  
25 any class 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 pur-  
25 poses 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 2004, 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 As-  
19 sociation 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  
2           the type referred to in section 801(b)(1), or  
3           their interests.

4           “(F) A representative of multiemployer  
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 “(c) 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 2004.

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  
14 /stop loss insurance (as defined in section  
15 806(g)(2)), other insurance related to the provision  
16 of medical care under the plan, or any combination  
17 thereof provided by such insurers or health mainte-  
18 nance organizations in such State in connection with  
19 such plan.

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

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

22 “(1) GROUP HEALTH PLAN.—The term ‘group  
23 health plan’ has the meaning provided in section  
24 733(a)(1) (after applying subsection (b) of this sec-  
25 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 plicable 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           2004, 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 2004 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, 2009, 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. 2003. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 8 **PLOYER ARRANGEMENTS.**

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

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        ployer 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. 2004. 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. 2005. 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. 2006. EFFECTIVE DATE AND TRANSITIONAL AND**  
14 **OTHER RULES.**

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

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 title, 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 title;

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 title 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.

Passed the House of Representatives May 12, 2004.

Attest:

*Clerk.*