

110TH CONGRESS  
2D SESSION

# H. R. 5923

To amend the Internal Revenue Code of 1986 to allow individuals a refundable and advancable credit against income tax for health insurance costs, to allow employees who elect not to participate in employer subsidized health plans an exclusion from gross income for employer payments in lieu of such participations, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 29, 2008

Mr. SHADEGG (for himself, Mrs. MUSGRAVE, Mr. WAMP, Mr. AKIN, Mr. CAMPBELL of California, Mr. DAVID DAVIS of Tennessee, Mr. KINGSTON, Mr. GINGREY, Mr. MARCHANT, Mr. ISSA, Mr. PENCE, Mr. FRANKS of Arizona, Mr. FORTUÑO, Mr. PITTS, Mr. WILSON of South Carolina, Mr. BROWN of South Carolina, Mr. BARTLETT of Maryland, Mr. SOUDER, and Mr. FEENEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Internal Revenue Code of 1986 to allow individuals a refundable and advancable credit against income tax for health insurance costs, to allow employees who elect not to participate in employer subsidized health plans an exclusion from gross income for employer payments in lieu of such participations, and for other purposes.

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

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

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

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

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

TITLE I—HEALTHMARTS

- Sec. 101. Expansion of consumer choice through Healthmarts.

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

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

TITLE III—FEDERAL MATCHING FUNDING FOR STATE  
 INSURANCE EXPENDITURES

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

TITLE IV—AFFORDABLE HEALTH COVERAGE FOR EMPLOYEES  
 OF SMALL BUSINESSES

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

TITLE V—IMPROVEMENT TO ACCESS AND CHOICE OF HEALTH  
 CARE

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

TITLE VI—PATIENT ACCESS TO INFORMATION

- Sec. 601. Patient access to information regarding plan coverage, managed care  
 procedures, health care providers, and quality of medical care.
- Sec. 602. Effective date.

1           (c) CONSTITUTIONAL AUTHORITY TO ENACT THIS  
2 LEGISLATION.—The constitutional authority upon which  
3 this Act rests is the power of Congress to regulate com-  
4 merce with foreign nations and among the several States,  
5 set forth in article I, section 8 of the United States Con-  
6 stitution.

7 **SEC. 2. FINDINGS.**

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

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

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

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

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

1           (4) THIRD-PARTY PAYMENT SYSTEMS.—Pay-  
2           ment by third-party payers (including commercial in-  
3           surance companies and various levels of government)  
4           for the preponderance of the health care delivered  
5           each year insulates patients, as well as physicians,  
6           hospitals, and other deliverers of health care, from  
7           the need to consider the cost of treatment in addi-  
8           tion to the medical benefit expected from it.

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

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

24          (7) LACK OF COMPETITION.—The present sys-  
25          tem of financing and regulation prevents health care

1 deliverers from competing with each other on the  
2 basis of efficiency and price as well as quality.

3 **SEC. 3. PURPOSES.**

4 The purposes of Act are—

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

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

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

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

19 (5) to simplify and rationalize the payment  
20 mechanism for health care services;

21 (6) to foster the development of numerous, var-  
22 ied, and innovative systems of providing health care  
23 which will compete against each other in terms of  
24 price, service, and quality, and thus allow the Amer-  
25 ican people to benefit from competitive forces which

1 will reward efficient and effective deliverers and  
2 eliminate those which provide unsatisfactory quality  
3 of care or are inefficient;

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

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

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

## 16 **TITLE I—HEALTHMARTS**

### 17 **SEC. 101. EXPANSION OF CONSUMER CHOICE THROUGH** 18 **HEALTHMARTS.**

19 The Public Health Service Act, as amended by sec-  
20 tion 2 of the Lifespan Respite Care Act of 2006 (Public  
21 Law 109–442), is amended by adding at the end the fol-  
22 lowing new title:

1       **“TITLE XXX—HEALTHMARTS**

2       **“SEC. 3001. DEFINITION OF HEALTHMART.**

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

6           “(1) ORGANIZATION.—The HealthMart is an  
7 organization operated under the direction of a board  
8 of directors which is composed of representatives of  
9 not fewer than 2 from each of the following:

10                   “(A) Employers.

11                   “(B) Employees.

12                   “(C) Individuals (other than those de-  
13 scribed in subparagraph (B)) who are eligible to  
14 participate in the HealthMart.

15                   “(D) Health care providers, which may be  
16 physicians, other health care professionals,  
17 health care facilities, or any combination there-  
18 of.

19                   “(E) Entities, such as insurance compa-  
20 nies, health maintenance organizations, and li-  
21 censed provider-sponsored organizations, that  
22 underwrite or administer health benefits cov-  
23 erage.

24           “(2) OFFERING HEALTH BENEFITS COV-  
25 ERAGE.—

1           “(A)       DIFFERENT       GROUPS.—The  
2           HealthMart, in conjunction with those health  
3           insurance issuers that offer health benefits cov-  
4           erage through the HealthMart, makes available  
5           health benefits coverage in the manner de-  
6           scribed in subsection (b) to all employers, eligi-  
7           ble employees, and individuals in the manner  
8           described in subsection (c)(2) at rates (includ-  
9           ing employer’s and employee’s share, if applica-  
10          ble) that are established by the health insurance  
11          issuer on a policy or product specific basis and  
12          that may vary only as permissible under State  
13          law. A HealthMart is deemed to be a group  
14          health plan for purposes of applying section 702  
15          of the Employee Retirement Income Security  
16          Act of 1974, section 2702 of this Act, and sec-  
17          tion 9802(b) of the Internal Revenue Code of  
18          1986 (which limit variation among similarly sit-  
19          uated individuals of required premiums for  
20          health benefits coverage on the basis of health  
21          status-related factors).

22               “(B) NONDISCRIMINATION IN COVERAGE  
23               OFFERED.—

24                       “(i) IN GENERAL.—Subject to clause  
25                       (ii), the HealthMart may not offer health

1 benefits coverage to an eligible employee or  
2 individual in a geographic area (as speci-  
3 fied under paragraph (3)(A)) unless the  
4 same coverage is offered to all such em-  
5 ployees or individuals in the same geo-  
6 graphic area. Section 2711(a)(1)(B) of this  
7 Act limits denial of enrollment of certain  
8 eligible individuals under health benefits  
9 coverage in the small group market.

10 “(ii) CONSTRUCTION.—Nothing in  
11 this title shall be construed as requiring or  
12 permitting a health insurance issuer to  
13 provide coverage outside the service area of  
14 the issuer, as approved under State law.

15 “(C) NO FINANCIAL UNDERWRITING.—The  
16 HealthMart provides health benefits coverage  
17 only through contracts with health insurance  
18 issuers and does not assume insurance risk with  
19 respect to such coverage.

20 “(D) MINIMUM COVERAGE.—By the end of  
21 the first year of its operation and thereafter,  
22 the HealthMart maintains not fewer than 10  
23 purchasers and 100 members.

24 “(3) GEOGRAPHIC AREAS.—

1           “(A) SPECIFICATION OF GEOGRAPHIC  
2 AREAS.—The HealthMart shall specify the geo-  
3 graphic area (or areas) in which it makes avail-  
4 able health benefits coverage offered by health  
5 insurance issuers to employers, or individuals,  
6 as the case may be. Any such area shall encom-  
7 pass at least one entire county or equivalent  
8 area.

9           “(B) MULTISTATE AREAS.—In the case of  
10 a HealthMart that serves more than one State,  
11 such geographic areas may be areas that in-  
12 clude portions of two or more contiguous  
13 States.

14           “(C) MULTIPLE HEALTHMARTS PER-  
15 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-  
16 ing in this title shall be construed as preventing  
17 the establishment and operation of more than  
18 one HealthMart in a geographic area or as lim-  
19 iting the number of HealthMarts that may op-  
20 erate in any area.

21           “(4) PROVISION OF ADMINISTRATIVE SERVICES  
22 TO PURCHASERS.—

23           “(A) IN GENERAL.—The HealthMart pro-  
24 vides administrative services for purchasers.  
25 Such services may include accounting, billing,

1 enrollment information, and employee coverage  
2 status reports.

3 “(B) CONSTRUCTION.—Nothing in this  
4 subsection shall be construed as preventing a  
5 HealthMart from serving as an administrative  
6 service organization to any entity.

7 “(5) DISSEMINATION OF INFORMATION.—The  
8 HealthMart collects and disseminates (or arranges  
9 for the collection and dissemination of) consumer-  
10 oriented information on the scope, cost, and enrollee  
11 satisfaction of all coverage options offered through  
12 the HealthMart to its members and eligible individ-  
13 uals. Such information shall be defined by the  
14 HealthMart and shall be in a manner appropriate to  
15 the type of coverage offered. To the extent prac-  
16 ticable, such information shall include information  
17 on provider performance, locations and hours of op-  
18 eration of providers, outcomes, and similar matters.  
19 Nothing in this section shall be construed as pre-  
20 venting the dissemination of such information or  
21 other information by the HealthMart or by health  
22 insurance issuers through electronic or other means.

23 “(6) FILING INFORMATION.—The Health-  
24 Mart—

1           “(A) files with the applicable Federal au-  
2           thority information that demonstrates the  
3           HealthMart’s compliance with the applicable re-  
4           quirements of this title; or

5           “(B) in accordance with rules established  
6           under section 3003(a), files with a State such  
7           information as the State may require to dem-  
8           onstrate such compliance.

9           “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
10          MENTS.—

11           “(1) COMPLIANCE WITH CONSUMER PROTEC-  
12          TION REQUIREMENTS.—Any health benefits coverage  
13          offered through a HealthMart shall—

14           “(A) be underwritten by a health insurance  
15          issuer that—

16           “(i) is licensed (or otherwise regu-  
17          lated) under State law;

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

21           “(iii) offers the coverage under a con-  
22          tract with the HealthMart;

23           “(B) subject to paragraph (2), be approved  
24          or otherwise permitted to be offered under  
25          State law; and

1           “(C) provide full portability of creditable  
2 coverage for individuals who remain members of  
3 the same HealthMart notwithstanding that they  
4 change the employer through which they are  
5 members in accordance with the provisions of  
6 the parts 6 and 7 of subtitle B of title I of the  
7 Employee Retirement Income Security Act of  
8 1974 and titles XXII and XXVII of this Act,  
9 so long as both employers are purchasers in the  
10 HealthMart, and notwithstanding that they ter-  
11minate such employment, if the HealthMart  
12permits enrollment directly by eligible individ-  
13uals.

14           “(2) ALTERNATIVE PROCESS FOR APPROVAL OF  
15 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMI-  
16NATION OR DELAY.—

17           “(A) IN GENERAL.—The requirement of  
18 paragraph (1)(B) shall not apply to a policy or  
19 product of health benefits coverage offered in a  
20 State if the health insurance issuer seeking to  
21 offer such policy or product files an application  
22 to waive such requirement with the applicable  
23 Federal authority, and the authority deter-  
24mines, based on the application and other evi-  
25dence presented to the authority, that—

1           “(i) either (or both) of the grounds  
2           described in subparagraph (B) for approval  
3           of the application has been met; and

4           “(ii) the coverage meets the applicable  
5           State standards (other than those that  
6           have been preempted under section 3002).

7           “(B) GROUNDS.—The grounds described  
8           in this subparagraph with respect to a policy or  
9           product of health benefits coverage are as fol-  
10          lows:

11           “(i) FAILURE TO ACT ON POLICY,  
12           PRODUCT, OR RATE APPLICATION ON A  
13           TIMELY BASIS.—The State has failed to  
14           complete action on the policy or product  
15           (or rates for the policy or product) within  
16           90 days of the date of the State’s receipt  
17           of a substantially complete application. No  
18           period before the date of the enactment of  
19           this section shall be included in deter-  
20           mining such 90-day period.

21           “(ii) DENIAL OF APPLICATION BASED  
22           ON DISCRIMINATORY TREATMENT.—The  
23           State has denied such an application  
24           and—

1           “(I) the standards or review  
2           process imposed by the State as a  
3           condition of approval of the policy or  
4           product imposes either any material  
5           requirements, procedures, or stand-  
6           ards to such policy or product that  
7           are not generally applicable to other  
8           policies and products offered or any  
9           requirements that are preempted  
10          under section 3002; or

11          “(II) the State requires the  
12          issuer, as a condition of approval of  
13          the policy or product, to offer any pol-  
14          icy or product other than such policy  
15          or product.

16          “(C) ENFORCEMENT.—In the case of a  
17          waiver granted under subparagraph (A) to an  
18          issuer with respect to a State, the Secretary  
19          may enter into an agreement with the State  
20          under which the State agrees to provide for  
21          monitoring and enforcement activities with re-  
22          spect to compliance of such an issuer and its  
23          health insurance coverage with the applicable  
24          State standards described in subparagraph  
25          (A)(ii). Such monitoring and enforcement shall

1 be conducted by the State in the same manner  
2 as the State enforces such standards with re-  
3 spect to other health insurance issuers and  
4 plans, without discrimination based on the type  
5 of issuer to which the standards apply. Such an  
6 agreement shall specify or establish mechanisms  
7 by which compliance activities are undertaken,  
8 while not lengthening the time required to re-  
9 view and process applications for waivers under  
10 subparagraph (A).

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

16 “(A) Coverage through a health mainte-  
17 nance organization.

18 “(B) Coverage in connection with a pre-  
19 ferred provider organization.

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

22 “(D) Indemnity coverage through an insur-  
23 ance company.

1           “(E) Coverage offered in connection with a  
2           contribution into a medical savings account or  
3           flexible spending account.

4           “(F) Coverage that includes a point-of-  
5           service option.

6           “(G) Any combination of such types of  
7           coverage.

8           “(4) WELLNESS BONUSES FOR HEALTH PRO-  
9           MOTION.—Nothing in this title shall be construed as  
10          precluding a health insurance issuer offering health  
11          benefits coverage through a HealthMart from estab-  
12          lishing premium discounts or rebates for members or  
13          from modifying otherwise applicable copayments or  
14          deductibles in return for adherence to programs of  
15          health promotion and disease prevention so long as  
16          such programs are agreed to in advance by the  
17          HealthMart and comply with all other provisions of  
18          this title and do not discriminate among similarly  
19          situated members.

20          “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE  
21          ISSUERS.—

22                 “(1) PURCHASERS.—

23                         “(A) IN GENERAL.—Subject to the provi-  
24                         sions of this title, a HealthMart shall permit  
25                         any employer or any individual described in

1 subsection (a)(1)(C) to contract with the  
2 HealthMart for the purchase of health benefits  
3 coverage for its employees and dependents of  
4 those employees or for the individual (and the  
5 individual's dependents), respectively, and may  
6 not vary conditions of eligibility (including pre-  
7 mium rates and membership fees) of an em-  
8 ployer or individual to be a purchaser.

9 “(B) ROLE OF ASSOCIATIONS, BROKERS,  
10 AND LICENSED HEALTH INSURANCE AGENTS.—  
11 Nothing in this section shall be construed as  
12 preventing an association, broker, licensed  
13 health insurance agent, or other entity from as-  
14 sisting or representing a HealthMart or employ-  
15 ers or individuals from entering into appro-  
16 priate arrangements to carry out this title.

17 “(C) PERIOD OF CONTRACT.—The  
18 HealthMart may not require a contract under  
19 subparagraph (A) between a HealthMart and a  
20 purchaser to be effective for a period of longer  
21 than 24 months. The previous sentence shall  
22 not be construed as preventing such a contract  
23 from being extended for additional 24-month  
24 periods or preventing the purchaser from volun-

1           tarily electing a contract period of longer than  
2           24 months.

3           “(D) EXCLUSIVE NATURE OF CON-  
4           TRACT.—

5                   “(i) IN GENERAL.—Subject to clause  
6                   (ii), such a contract shall provide that the  
7                   purchaser agrees not to obtain or sponsor  
8                   health benefits coverage, on behalf of any  
9                   eligible employees (and their dependents),  
10                  other than through the HealthMart.

11                   “(ii) EXCEPTION IF NO COVERAGE OF-  
12                   FERED IN AREA OF RESIDENCES.—Clause  
13                   (i) shall not apply to an eligible individual  
14                   who resides in an area for which no cov-  
15                   erage is offered by any health insurance  
16                   issuer through the HealthMart.

17                   “(iii) NOTHING PRECLUDING INDI-  
18                   VIDUAL EMPLOYEE OPT-OUT.—Nothing in  
19                   this subparagraph shall be construed as re-  
20                   quiring an eligible employee of a large or  
21                   small employer that is a purchaser to ob-  
22                   tain health benefits coverage through the  
23                   HealthMart.

24           “(2) MEMBERS.—

25                   “(A) IN GENERAL.—

1           “(i) EMPLOYMENT BASED MEMBER-  
2 SHIP.—Under rules established to carry  
3 out this title, with respect to an employer  
4 that has a purchaser contract with a  
5 HealthMart, individuals who are employees  
6 of the employer may enroll for health bene-  
7 fits coverage (including coverage for de-  
8 pendents of such enrolling employees) of-  
9 fered by a health insurance issuer through  
10 the HealthMart.

11           “(ii) INDIVIDUALS.—Under rules es-  
12 tablished to carry out this title, with re-  
13 spect to an individual who has a purchaser  
14 contract with a HealthMart for himself or  
15 herself, the individual may enroll for health  
16 benefits coverage (including coverage for  
17 dependents of such individual) offered by a  
18 health insurance issuer through the  
19 HealthMart.

20           “(B) NONDISCRIMINATION IN ENROLL-  
21 MENT.—A HealthMart may not deny enroll-  
22 ment as a member to an individual who is an  
23 employee or individual (or dependent of such an  
24 employee or individual) eligible to be so enrolled  
25 based on health status-related factors, except as

1           may be permitted consistent with section  
2           2742(b).

3           “(C) ANNUAL OPEN ENROLLMENT PE-  
4           RIOD.—In the case of members enrolled in  
5           health benefits coverage offered by a health in-  
6           surance issuer through a HealthMart, subject  
7           to subparagraph (D), the HealthMart shall pro-  
8           vide for an annual open enrollment period of 30  
9           days during which such members may change  
10          the coverage option in which the members are  
11          enrolled.

12          “(D) RULES OF ELIGIBILITY.—Nothing in  
13          this paragraph shall preclude a HealthMart  
14          from establishing rules of employee or indi-  
15          vidual eligibility for enrollment and reenroll-  
16          ment of members during the annual open en-  
17          rollment period under subparagraph (C). Such  
18          rules shall be applied consistently to all pur-  
19          chasers and members within the HealthMart  
20          and shall not be based in any manner on health  
21          status-related factors and may not conflict with  
22          sections 2701 and 2702 of this Act.

23          “(3) HEALTH INSURANCE ISSUERS.—

24                 “(A) PREMIUM COLLECTION.—The con-  
25                 tract between a HealthMart and a health insur-

1           ance issuer shall provide, with respect to a  
2           member enrolled with health benefits coverage  
3           offered by the issuer through the HealthMart,  
4           for the payment of the premiums collected by  
5           the HealthMart (or the issuer) for such cov-  
6           erage (less a pre-determined administrative  
7           charge negotiated by the HealthMart and the  
8           issuer) to the issuer.

9           “(B) SCOPE OF SERVICE AREA.—Nothing  
10          in this title shall be construed as requiring the  
11          service area of a health insurance issuer with  
12          respect to health insurance coverage to cover  
13          the entire geographic area served by a  
14          HealthMart.

15          “(C) AVAILABILITY OF COVERAGE OP-  
16          TIONS.—

17               “(i) IN GENERAL.—A HealthMart  
18               shall enter into contracts with one or more  
19               health insurance issuers in a manner that  
20               assures that at least 2 health insurance  
21               coverage options are made available.

22               “(ii) REQUIREMENT OF NON-NET-  
23               WORK OPTION.—At least one of the health  
24               insurance coverage options made available  
25               under clause (i) shall be a non-network

1 coverage option under which enrollees may  
2 obtain benefits for health care items and  
3 services that are not provided under a con-  
4 tract between the provider of the service  
5 and the issuer involved.

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

7 “(1) FOR BOARDS OF DIRECTORS.—A member  
8 of a board of directors of a HealthMart may not  
9 serve as an employee or paid consultant to the  
10 HealthMart, but may receive reasonable reimburse-  
11 ment for travel expenses for purposes of attending  
12 meetings of the board or committees thereof.

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

23 “(3) EMPLOYMENT AND EMPLOYEE REP-  
24 RESENTATIVES.—

1           “(A) IN GENERAL.—An individual who is  
2           serving on a board of directors of a HealthMart  
3           as a representative described in subparagraph  
4           (A) or (B) of section 3001(a)(1) shall not be  
5           employed by or affiliated with a health insur-  
6           ance issuer or be licensed as or employed by or  
7           affiliated with a health care provider.

8           “(B) CONSTRUCTION.—For purposes of  
9           subparagraph (A), the term ‘affiliated’ does not  
10          include membership in a health benefits plan or  
11          the obtaining of health benefits coverage offered  
12          by a health insurance issuer.

13          “(e) CONSTRUCTION.—

14                 “(1)           NETWORK           OF           AFFILIATED  
15           HEALTHMARTS.—Nothing in this section shall be  
16           construed as preventing one or more HealthMarts  
17           serving different areas (whether or not contiguous)  
18           from providing for some or all of the following  
19           (through a single administrative organization or oth-  
20           erwise):

21                 “(A) Coordinating the offering of the same  
22                 or similar health benefits coverage in different  
23                 areas served by the different HealthMarts.

24                 “(B) Providing for crediting of deductibles  
25                 and other cost-sharing for individuals who are

1 provided health benefits coverage through the  
2 HealthMarts (or affiliated HealthMarts)  
3 after—

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

6 “(ii) a change in place of employment  
7 to an area not served by the previous  
8 HealthMart.

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

19 **“SEC. 3002. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
20 **MENTS.**

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

1           “(1) The regulation of underwriters of health  
2 coverage, including licensure and solvency require-  
3 ments.

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

7           “(3) The application of fair marketing require-  
8 ments and other consumer protections (other than  
9 those specifically relating to an item described in  
10 subsection (b)).

11           “(4) The application of requirements relating to  
12 the adjustment of rates for health insurance cov-  
13 erage.

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

19           “(1) Benefit requirements for health benefits  
20 coverage offered through a HealthMart, including  
21 (but not limited to) requirements relating to cov-  
22 erage of specific providers, specific services or condi-  
23 tions, or the amount, duration, or scope of benefits,  
24 but not including requirements to the extent re-  
25 quired to implement title XXVII or other Federal

1 law and to the extent the requirement prohibits an  
2 exclusion of a specific disease from such coverage.

3 “(2) Requirements (commonly referred to as  
4 fictitious group laws) relating to grouping and simi-  
5 lar requirements for such coverage to the extent  
6 such requirements impede the establishment and op-  
7 eration of HealthMarts pursuant to this title.

8 “(3) Any other requirements (including limita-  
9 tions on compensation arrangements) that, directly  
10 or indirectly, preclude (or have the effect of pre-  
11 cluding) the offering of such coverage through a  
12 HealthMart, if the HealthMart meets the require-  
13 ments of this title.

14 Any State law or regulation relating to the composition  
15 or organization of a HealthMart is preempted to the ex-  
16 tent the law or regulation is inconsistent with the provi-  
17 sions of this title.

18 “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-  
19 CLOSURE REQUIREMENTS.—The board of directors of a  
20 HealthMart is deemed to be a plan administrator of an  
21 employee welfare benefit plan which is a group health plan  
22 for purposes of applying parts 1 and 4 of subtitle B of  
23 title I of the Employee Retirement Income Security Act  
24 of 1974 and those provisions of part 5 of such subtitle  
25 which are applicable to enforcement of such parts 1 and

1 4, and the HealthMart shall be treated as such a plan  
2 and the enrollees enrolled on the basis of employment shall  
3 be treated as participants and beneficiaries for purposes  
4 of applying such provisions pursuant to this subsection.

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

10 “(e) APPLICATION OF RULES FOR NETWORK PLANS  
11 AND FINANCIAL CAPACITY.—The provisions of sub-  
12 sections (c) and (d) of section 2711 apply to health bene-  
13 fits coverage offered by a health insurance issuer through  
14 a HealthMart.

15 “(f) CONSTRUCTION RELATING TO OFFERING RE-  
16 QUIREMENT.—Nothing in section 2711(a) of this Act or  
17 703 of the Employee Retirement Income Security Act of  
18 1974 shall be construed as permitting the offering outside  
19 the HealthMart of health benefits coverage that is only  
20 made available through a HealthMart under this section  
21 because of the application of subsection (b).

22 “(g) APPLICATION TO GUARANTEED RENEWABILITY  
23 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN  
24 ISSUER.—For purposes of applying section 2712 in the  
25 case of health insurance coverage offered by a health in-

1 surance issuer through a HealthMart, if the contract be-  
2 tween the HealthMart and the issuer is terminated and  
3 the HealthMart continues to make available any health in-  
4 surance coverage after the date of such termination, the  
5 following rules apply:

6           “(1) RENEWABILITY.—The HealthMart shall  
7 fulfill the obligation under such section of the issuer  
8 renewing and continuing in force coverage by offer-  
9 ing purchasers (and members and their dependents)  
10 all available health benefits coverage that would oth-  
11 erwise be available to similarly-situated purchasers  
12 and members from the remaining participating  
13 health insurance issuers in the same manner as  
14 would be required of issuers under section 2712(c).

15           “(2) APPLICATION OF ASSOCIATION RULES.—  
16 The HealthMart shall be considered an association  
17 for purposes of applying section 2712(e).

18           “(h) CONSTRUCTION IN RELATION TO CERTAIN  
19 OTHER LAWS.—Nothing in this title shall be construed  
20 as modifying or affecting the applicability to HealthMarts  
21 or health benefits coverage offered by a health insurance  
22 issuer through a HealthMart of parts 6 and 7 of subtitle  
23 B of title I of the Employee Retirement Income Security  
24 Act of 1974 or titles XXII and XXVII of this Act.

1 **“SEC. 3003. ADMINISTRATION.**

2       “(a) IN GENERAL.—The applicable Federal authority  
3 shall administer this title and is authorized to issue such  
4 regulations as may be required to carry out this title. Such  
5 regulations shall be subject to Congressional review under  
6 the provisions of chapter 8 of title 5, United States Code.  
7 The applicable Federal authority shall incorporate the  
8 process of ‘deemed file and use’ with respect to the infor-  
9 mation filed under section 3001(a)(6)(A) and shall deter-  
10 mine whether information filed by a HealthMart dem-  
11 onstrates compliance with the applicable requirements of  
12 this title. Such authority shall exercise its authority under  
13 this title in a manner that fosters and promotes the devel-  
14 opment of HealthMarts in order to improve access to  
15 health care coverage and services.

16       “(b) PERIODIC REPORTS.—The applicable Federal  
17 authority shall submit to Congress a report every 30  
18 months, during the 10-year period beginning on the effec-  
19 tive date of the rules promulgated by the applicable Fed-  
20 eral authority to carry out this title, on the effectiveness  
21 of this title in promoting coverage of uninsured individ-  
22 uals. Such authority may provide for the production of  
23 such reports through one or more contracts with appro-  
24 priate private entities.

25 **“SEC. 3004. DEFINITIONS.**

26       “For purposes of this title:

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

4           “(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—  
5 The term ‘eligible’ means, with respect to an em-  
6 ployee or other individual and a HealthMart, an em-  
7 ployee or individual who is eligible under section  
8 3001(e)(2) to enroll or be enrolled in health benefits  
9 coverage offered through the HealthMart.

10          “(3) EMPLOYER; EMPLOYEE; DEPENDENT.—  
11 Except as the applicable Federal authority may oth-  
12 erwise provide, the terms ‘employer’, ‘employee’, and  
13 ‘dependent’, as applied to health insurance coverage  
14 offered by a health insurance issuer licensed (or oth-  
15 erwise regulated) in a State, shall have the meanings  
16 applied to such terms with respect to such coverage  
17 under the laws of the State relating to such coverage  
18 and such an issuer. The term ‘dependent’ may in-  
19 clude the spouse and children of the individual in-  
20 volved.

21          “(4) HEALTH BENEFITS COVERAGE.—The term  
22 ‘health benefits coverage’ has the meaning given the  
23 term group health insurance coverage in section  
24 2791(b)(4).

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

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

7           “(7) HEALTHMART.—The term ‘HealthMart’ is  
8           defined in section 3001(a).

9           “(8) MEMBER.—The term ‘member’ means,  
10          with respect to a HealthMart, an individual enrolled  
11          for health benefits coverage through the HealthMart  
12          under section 3001(c)(2).

13          “(9) PURCHASER.—The term ‘purchaser’  
14          means, with respect to a HealthMart, an employer  
15          or individual that has contracted under section  
16          3001(c)(1)(A) with the HealthMart for the purchase  
17          of health benefits coverage.”.

1 **TITLE II—HEALTH CARE ACCESS**  
 2 **AND CHOICE THROUGH INDI-**  
 3 **VIDUAL MEMBERSHIP ASSO-**  
 4 **CIATIONS (IMAS)**

5 **SEC. 201. EXPANSION OF ACCESS AND CHOICE THROUGH**  
 6 **INDIVIDUAL MEMBERSHIP ASSOCIATIONS**  
 7 **(IMAS).**

8 The Public Health Service Act, as amended by sec-  
 9 tion 102, is further amended by adding at the end the  
 10 following new title:

11 **“TITLE XXXI—INDIVIDUAL**  
 12 **MEMBERSHIP ASSOCIATIONS**

13 **“SEC. 3101. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-**  
 14 **SOCIATION (IMA).**

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

18 “(1) ORGANIZATION.—The IMA is an organiza-  
 19 tion operated under the direction of an association  
 20 (as defined in section 3104(1)).

21 “(2) OFFERING HEALTH BENEFITS COV-  
 22 ERAGE.—

23 “(A) DIFFERENT GROUPS.—The IMA, in  
 24 conjunction with those health insurance issuers  
 25 that offer health benefits coverage through the

1 IMA, makes available health benefits coverage  
2 in the manner described in subsection (b) to all  
3 members of the IMA and the dependents of  
4 such members in the manner described in sub-  
5 section (c)(2) at rates that are established by  
6 the health insurance issuer on a policy or prod-  
7 uct specific basis and that may vary only as  
8 permissible under State law.

9 “(B) NONDISCRIMINATION IN COVERAGE  
10 OFFERED.—

11 “(i) IN GENERAL.—Subject to clause  
12 (ii), the IMA may not offer health benefits  
13 coverage to a member of an IMA unless  
14 the same coverage is offered to all such  
15 members of the IMA.

16 “(ii) CONSTRUCTION.—Nothing in  
17 this title shall be construed as requiring or  
18 permitting a health insurance issuer to  
19 provide coverage outside the service area of  
20 the issuer, as approved under State law, or  
21 requiring a health insurance issuer from  
22 excluding or limiting the coverage on any  
23 individual, subject to the requirement of  
24 section 2741.

1           “(C) NO FINANCIAL UNDERWRITING.—The  
2           IMA provides health benefits coverage only  
3           through contracts with health insurance issuers  
4           and does not assume insurance risk with re-  
5           spect to such coverage.

6           “(3) GEOGRAPHIC AREAS.—Nothing in this title  
7           shall be construed as preventing the establishment  
8           and operation of more than one IMA in a geographic  
9           area or as limiting the number of IMAs that may  
10          operate in any area.

11          “(4) PROVISION OF ADMINISTRATIVE SERVICES  
12          TO PURCHASERS.—

13                 “(A) IN GENERAL.—The IMA may provide  
14                 administrative services for members. Such serv-  
15                 ices may include accounting, billing, and enroll-  
16                 ment information.

17                 “(B) CONSTRUCTION.—Nothing in this  
18                 subsection shall be construed as preventing an  
19                 IMA from serving as an administrative service  
20                 organization to any entity.

21          “(5) FILING INFORMATION.—The IMA files  
22          with the Secretary information that demonstrates  
23          the IMA’s compliance with the applicable require-  
24          ments of this title.

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

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

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

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

10                               “(ii) meets all applicable State stand-  
11 ards relating to consumer protection, sub-  
12 ject to section 3002(b), and

13                       “(B) subject to paragraph (2), be approved  
14 or otherwise permitted to be offered under  
15 State law.

16               “(2) EXAMPLES OF TYPES OF COVERAGE.—The  
17 benefits coverage made available through an IMA  
18 may include, but is not limited to, any of the fol-  
19 lowing if it meets the other applicable requirements  
20 of this title:

21                       “(A) Coverage through a health mainte-  
22 nance organization.

23                       “(B) Coverage in connection with a pre-  
24 ferred provider organization.

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

3           “(D) Indemnity coverage through an insur-  
4           ance company.

5           “(E) Coverage offered in connection with a  
6           contribution into a medical savings account or  
7           flexible spending account.

8           “(F) Coverage that includes a point-of-  
9           service option.

10          “(G) Any combination of such types of  
11          coverage.

12          “(3) WELLNESS BONUSES FOR HEALTH PRO-  
13          MOTION.—Nothing in this title shall be construed as  
14          precluding a health insurance issuer offering health  
15          benefits coverage through an IMA from establishing  
16          premium discounts or rebates for members or from  
17          modifying otherwise applicable copayments or  
18          deductibles in return for adherence to programs of  
19          health promotion and disease prevention so long as  
20          such programs are agreed to in advance by the IMA  
21          and comply with all other provisions of this title and  
22          do not discriminate among similarly situated mem-  
23          bers.

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

25          “(1) MEMBERS.—

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

8           “(B) RULES FOR ENROLLMENT.—Nothing  
9           in this paragraph shall preclude an IMA from  
10          establishing rules of enrollment and reenroll-  
11          ment of members. Such rules shall be applied  
12          consistently to all members within the IMA and  
13          shall not be based in any manner on health sta-  
14          tus-related factors.

15          “(2) HEALTH INSURANCE ISSUERS.—The con-  
16          tract between an IMA and a health insurance issuer  
17          shall provide, with respect to a member enrolled with  
18          health benefits coverage offered by the issuer  
19          through the IMA, for the payment of the premiums  
20          collected by the issuer.

21       **“SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
22       **MENTS.**

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

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

10           “(2) Any other requirements (including limita-  
11 tions on compensation arrangements) that, directly  
12 or indirectly, preclude (or have the effect of pre-  
13 cluding) the offering of such coverage through an  
14 IMA, if the IMA meets the requirements of this  
15 title.

16 Any State law or regulation relating to the composition  
17 or organization of an IMA is preempted to the extent the  
18 law or regulation is inconsistent with the provisions of this  
19 title.

20 **“SEC. 3103. ADMINISTRATION.**

21           “(a) IN GENERAL.—The Secretary shall administer  
22 this title and is authorized to issue such regulations as  
23 may be required to carry out this title. Such regulations  
24 shall be subject to Congressional review under the provi-  
25 sions of chapter 8 of title 5, United States Code. The Sec-

1 retary shall incorporate the process of ‘deemed file and  
2 use’ with respect to the information filed under section  
3 3001(a)(5)(A) and shall determine whether information  
4 filed by an IMA demonstrates compliance with the applica-  
5 ble requirements of this title. The Secretary shall exercise  
6 authority under this title in a manner that fosters and  
7 promotes the development of IMAs in order to improve  
8 access to health care coverage and services.

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

17 **“SEC. 3104. DEFINITIONS.**

18       “For purposes of this title:

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

22                       “(A) has been actively in existence for at  
23                       least 5 years;

1           “(B) has been formed and maintained in  
2           good faith for purposes other than obtaining in-  
3           surance;

4           “(C) does not condition membership in the  
5           association on any health status-related factor  
6           relating to an individual (including an employee  
7           of an employer or a dependent of an employee);  
8           and

9           “(D) does not make health insurance cov-  
10          erage offered through the association available  
11          other than in connection with a member of the  
12          association.

13          “(2) DEPENDENT.—The term ‘dependent’, as  
14          applied to health insurance coverage offered by a  
15          health insurance issuer licensed (or otherwise regu-  
16          lated) in a State, shall have the meaning applied to  
17          such term with respect to such coverage under the  
18          laws of the State relating to such coverage and such  
19          an issuer. Such term may include the spouse and  
20          children of the individual involved.

21          “(3) HEALTH BENEFITS COVERAGE.—The term  
22          ‘health benefits coverage’ has the meaning given the  
23          term health insurance coverage in section  
24          2791(b)(1).

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

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

7           “(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIA-  
8           TION.—The terms ‘IMA’ and ‘individual membership  
9           association’ are defined in section 3101(a).

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

14   **TITLE III—FEDERAL MATCHING**  
15   **FUNDING FOR STATE INSUR-**  
16   **ANCE EXPENDITURES**

17   **SEC. 301. FEDERAL MATCHING FUNDING FOR STATE IN-**  
18   **SURANCE EXPENDITURES.**

19           (a) IN GENERAL.—Subject to the succeeding provi-  
20           sions of this section, each State shall receive from the Sec-  
21           retary of Health and Human Services an amount equal  
22           to 50 percent of the funds expended by the State in pro-  
23           viding for the use, in connection with providing health ben-  
24           efits coverage, of a high-risk pool, a reinsurance pool, or

1 other risk-adjustment mechanism used for the purpose of  
2 subsidizing the purchase of private health insurance.

3 (b) FUNDING LIMITATION.—A State shall not receive  
4 under this section for a fiscal year more than a total of  
5 50 cents multiplied by the average number of residents  
6 (as estimated by the Secretary) in the State in the fiscal  
7 year.

8 (c) ADMINISTRATION.—The Secretary of Health and  
9 Human Services shall provide for the administration of  
10 this section and may establish such terms and conditions,  
11 including the requirement of an application, as may be ap-  
12 propriate to carry out this section.

13 (d) CONSTRUCTION.—Nothing in this section shall be  
14 construed as requiring a State to operate a reinsurance  
15 pool (or other risk-adjustment mechanism) under this sec-  
16 tion or as preventing a State from operating such a pool  
17 or mechanism through one or more private entities.

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

22 (f) REINSURANCE POOL OR OTHER RISK-ADJUST-  
23 MENT MECHANISM DEFINED.—For purposes of this sec-  
24 tion, the term “reinsurance pool or other risk-adjustment  
25 mechanism” means any State-based risk spreading mecha-

1 nism to subsidize the purchase of private health insurance  
2 for the high-risk population.

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

5 (1) individuals who, by reason of the existence  
6 or history of a medical condition, are able to acquire  
7 health coverage only at rates which are at least 150  
8 percent of the standard risk rates for such coverage,  
9 and

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

12 (h) STATE DEFINED.—For purposes of this section,  
13 the term “State” includes the District of Columbia, Puer-  
14 to Rico, the Virgin Islands, Guam, American Samoa, and  
15 the Northern Mariana Islands.

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

19 **SEC. 401. SHORT TITLE OF TITLE.**

20 This title may be cited as the “Small Business Access  
21 and Choice for Entrepreneurs Act of 2007”.

22 **SEC. 402. RULES.**

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

1           **“PART —RULES GOVERNING ASSOCIATION**

2                                   **HEALTH PLANS**

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

4           “(a) IN GENERAL.—For purposes of this part, the  
5 term ‘association health plan’ means a group health  
6 plan—

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

9                   “(2) under which at least one option of health  
10 insurance coverage offered by a health insurance  
11 issuer (which may include, among other options,  
12 managed care options, point of service options, and  
13 preferred provider options) is provided to partici-  
14 pants and beneficiaries, unless, for any plan year,  
15 such coverage remains unavailable to the plan de-  
16 spite good faith efforts exercised by the plan to se-  
17 cure such coverage.

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-  
26 phone cooperative association), a bona fide profes-

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

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

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

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

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

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

9 “(b) STANDARDS.—Under the procedure prescribed  
10 pursuant to subsection (a), in the case of an association  
11 health plan that provides at least one benefit option which  
12 does not consist of health insurance coverage, the applica-  
13 ble authority shall certify such plan as meeting the re-  
14 quirements of this part only if the applicable authority is  
15 satisfied that—

16 “(1) such certification—

17 “(A) is administratively feasible;

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

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

22 “(2) the applicable requirements of this part  
23 are met (or, upon the date on which the plan is to  
24 commence operations, will be met) with respect to  
25 the plan.

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

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

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

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

1           “(1) a plan which offered such coverage on the  
2           date of the enactment of the Small Business Access  
3           and Choice for Entrepreneurs Act of 2007;

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

9           “(3) a plan whose eligible participating employ-  
10          ers represent one or more trades or businesses, or  
11          one or more industries, which have been indicated as  
12          having average or above-average health insurance  
13          risk or health claims experience by reason of State  
14          rate filings, denials of coverage, proposed premium  
15          rate levels, and other means demonstrated by such  
16          plan in accordance with regulations which the Sec-  
17          retary shall prescribe through negotiated rule-  
18          making, including (but not limited to) the following:  
19          agriculture; automobile dealerships; barbering and  
20          cosmetology; child care; construction; dance, theat-  
21          rical, and orchestra productions; disinfecting and  
22          pest control; eating and drinking establishments;  
23          fishing; hospitals; labor organizations; logging; man-  
24          ufacturing (metals); mining; medical and dental

1 practices; medical laboratories; sanitary services;  
2 transportation (local and freight); and warehousing.

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

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

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

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

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

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

4           “(A) IN GENERAL.—Except as provided in  
5 subparagraphs (B) and (C), the members of the  
6 board of trustees are individuals selected from  
7 individuals who are the owners, officers, direc-  
8 tors, or employees of the participating employ-  
9 ers or who are partners in the participating em-  
10 ployers and actively participate in the business.

11           “(B) LIMITATION.—

12           “(i) GENERAL RULE.—Except as pro-  
13 vided in clauses (ii) and (iii), no such  
14 member is an owner, officer, director, or  
15 employee of, or partner in, a contract ad-  
16 ministrator or other service provider to the  
17 plan.

18           “(ii) LIMITED EXCEPTION FOR PRO-  
19 VIDERS OF SERVICES SOLELY ON BEHALF  
20 OF THE SPONSOR.—Officers or employees  
21 of a sponsor which is a service provider  
22 (other than a contract administrator) to  
23 the plan may be members of the board if  
24 they constitute not more than 25 percent  
25 of the membership of the board and they

1 do not provide services to the plan other  
2 than on behalf of the sponsor.

3 “(iii) TREATMENT OF PROVIDERS OF  
4 MEDICAL CARE.—In the case of a sponsor  
5 which is an association whose membership  
6 consists primarily of providers of medical  
7 care, clause (i) shall not apply in the case  
8 of any service provider described in sub-  
9 paragraph (A) who is a provider of medical  
10 care under the plan.

11 “(C) CERTAIN PLANS EXCLUDED.—Sub-  
12 paragraph (A) shall not apply to an association  
13 health plan which is in existence on the date of  
14 the enactment of the Small Business Access  
15 and Choice for Entrepreneurs Act of 2007.

16 “(D) SOLE AUTHORITY.—The board has  
17 sole authority under the plan to approve appli-  
18 cations for participation in the plan and to con-  
19 tract with a service provider to administer the  
20 day-to-day affairs of the plan.

21 “(e) TREATMENT OF FRANCHISE NETWORKS.—In  
22 the case of a group health plan which is established and  
23 maintained by a franchiser for a franchise network con-  
24 sisting of its franchisees—

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

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

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

14       “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

19           “(B) the joint board of trustees shall be  
20           deemed a board of trustees with respect to  
21           which the requirements of subsection (b) are  
22           met; and

23           “(C) the requirements of section 804 shall  
24           be deemed met.

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

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

4                   “(B) the plan is in existence on April 1,  
5 1997, and would be described in section  
6 3(40)(A)(i) but solely for the failure to meet  
7 the requirements of section 3(40)(C)(ii).

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 Access and Choice for Entrepreneurs Act of 2007,  
17 an affiliated member of the sponsor of the plan may be  
18 offered coverage under the plan as a participating em-  
19 ployer only if—

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

23 “(2) during the 12-month period preceding the  
24 date of the offering of such coverage, the affiliated  
25 member has not maintained or contributed to a

1 group health plan with respect to any of its employ-  
2 ees who would otherwise be eligible to participate in  
3 such association health plan.

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

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

20 “(1) under the terms of the plan, all employers  
21 meeting the preceding requirements of this section  
22 are eligible to qualify as participating employers for  
23 all geographically available coverage options, unless,  
24 in the case of any such employer, participation or  
25 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 the claims experience of such employer  
11 and do not vary on the basis of the type of  
12 business or industry in which such employer is  
13 engaged.

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

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

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

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

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

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

15          “(4) MARKETING REQUIREMENTS.—

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

24                 “(B) STATE-LICENSED INSURANCE  
25                 AGENTS.—For purposes of subparagraph (A),

1           the term ‘State-licensed insurance agents’  
2           means one or more agents who are licensed in  
3           a State and are subject to the laws of such  
4           State relating to licensure, qualification, test-  
5           ing, examination, and continuing education of  
6           persons authorized to offer, sell, or solicit  
7           health insurance coverage in such State.

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

13          “(b) HEALTH BENEFIT OPTIONS UNDER AN ASSO-  
14          CIATION HEALTH PLAN.—

15                 “(1) EXAMPLES OF TYPES OF COVERAGE.—The  
16                 health benefits coverage made available through an  
17                 association health plan may include, but is not lim-  
18                 ited to, any of the following if it meets the other ap-  
19                 plicable requirements of this title:

20                         “(A) Coverage through a health mainte-  
21                         nance organization.

22                         “(B) Coverage in connection with a pre-  
23                         ferred provider organization.

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

1           “(D) Indemnity coverage through an insur-  
2           ance company.

3           “(E) Coverage offered in connection with a  
4           contribution into a medical savings account or  
5           flexible spending account.

6           “(F) Coverage that includes a point-of-  
7           service option.

8           “(G) Any combination of such types of  
9           coverage.

10          “(2) HEALTH INSURANCE COVERAGE OP-  
11          TIONS.—

12           “(A) IN GENERAL.—An association health  
13           plan shall include a minimum of 4 health insur-  
14           ance coverage options. At least 1 option shall be  
15           a non network option. At least 2 options shall  
16           meet all applicable State benefit mandates.

17           “(B) MODEL BENEFITS PACKAGE.—The  
18           Secretary in consultation with the National As-  
19           sociation of Insurance Commissioners shall de-  
20           velop a model benefits package for health insur-  
21           ance coverage not later than one year after the  
22           date of the enactment of the Consensus Health  
23           Care Access and Choice Act of 2003.

24           “(C) EXCEPTION TO GENERAL RULE.—An  
25           association health plan may offer 2 options that

1 meet the requirements of the model benefits  
2 package in lieu of the State benefit mandate of-  
3 ferings required under subparagraph (A).

4 “(3) PERMITTING ASSOCIATION HEALTH PLANS  
5 TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO RE-  
6 FLECT RELATIVE RISK OF ENROLLEES.—Nothing in  
7 this section shall be construed as precluding an asso-  
8 ciation health plan from providing for adjustments  
9 in amounts distributed among the health insurance  
10 issuers offering health benefits coverage through the  
11 association health plan based on factors such as the  
12 relative health care risk of members enrolled under  
13 the coverage offered by the different issuers.

14 “(4) CONSTRUCTION.—Except as provided in  
15 subparagraph (2), nothing in this part or any provi-  
16 sion of State law (as defined in section 514(c)(1))  
17 shall be construed to preclude an association health  
18 plan, or a health insurance issuer offering health in-  
19 surance coverage in connection with an association  
20 health plan, from exercising its sole discretion in se-  
21 lecting the specific items and services consisting of  
22 medical care to be included as benefits under such  
23 plan or coverage, except (subject to section 514) in  
24 the case of any law to the extent that it (1) prohibits  
25 an exclusion of a specific disease from such cov-

1 erage, or (2) is not preempted under section  
2 731(a)(1) with respect to matters governed by sec-  
3 tion 711 or 712.

4 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
5 **FOR SOLVENCY FOR PLANS PROVIDING**  
6 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
7 **INSURANCE COVERAGE.**

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

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

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

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

19 “(i) a reserve sufficient for unearned  
20 contributions;

21 “(ii) a reserve sufficient for benefit li-  
22 abilities which have been incurred, which  
23 have not been satisfied, and for which risk  
24 of loss has not yet been transferred, and

1 for expected administrative costs with re-  
2 spect to such benefit liabilities;

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

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

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

14 “(i) The plan shall secure aggregate  
15 excess/stop loss insurance for the plan with  
16 an attachment point which is not greater  
17 than 125 percent of expected gross annual  
18 claims. The applicable authority may by  
19 regulation, through negotiated rulemaking,  
20 provide for upward adjustments in the  
21 amount of such percentage in specified cir-  
22 cumstances in which the plan specifically  
23 provides for and maintains reserves in ex-  
24 cess of the amounts required under sub-  
25 paragraph (A).

1           “(ii) The plan shall secure specific ex-  
2           cess/stop loss insurance for the plan with  
3           an attachment point which is at least equal  
4           to an amount recommended by the plan’s  
5           qualified actuary (but not more than  
6           \$175,000). The applicable authority may  
7           by regulation, through negotiated rule-  
8           making, provide for adjustments in the  
9           amount of such insurance in specified cir-  
10          cumstances in which the plan specifically  
11          provides for and maintains reserves in ex-  
12          cess of the amounts required under sub-  
13          paragraph (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 regulations prescribed by the applicable authority  
19 pursuant to clause (i) or (ii) of subparagraph (B) may  
20 allow for such adjustments in the required levels of excess/  
21 stop loss insurance as the qualified actuary may rec-  
22 ommend, taking into account the specific circumstances  
23 of the plan.

24           “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS  
25 RESERVES.—In the case of any association health plan de-

1 scribed in subsection (a)(2), the requirements of this sub-  
2 section are met if the plan establishes and maintains sur-  
3 plus in an amount at least equal to—

4 “(1) \$500,000; or

5 “(2) such greater amount (but not greater than  
6 \$2,000,000) as may be set forth in regulations pre-  
7 scribed by the applicable authority through nego-  
8 tiated rulemaking, based on the level of aggregate  
9 and specific excess/stop loss insurance provided with  
10 respect to such plan.

11 “(c) ADDITIONAL REQUIREMENTS.—In the case of  
12 any association health plan described in subsection (a)(2),  
13 the applicable authority may provide such additional re-  
14 quirements relating to reserves and excess/stop loss insur-  
15 ance as the applicable authority considers appropriate.  
16 Such requirements may be provided by regulation, through  
17 negotiated rulemaking, with respect to any such plan or  
18 any class of such plans.

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

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

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

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

24                       “(A) IN GENERAL.—In the case of an as-  
25 sociation health plan described in subsection

1 (a)(2), the requirements of this subsection are  
2 met if the plan makes payments into the Asso-  
3 ciation Health Plan Fund under this subpara-  
4 graph when they are due. Such payments shall  
5 consist of annual payments in the amount of  
6 \$5,000, and, in addition to such annual pay-  
7 ments, such supplemental payments as the Sec-  
8 retary may determine to be necessary under  
9 paragraph (2). Payments under this paragraph  
10 are payable to the Fund at the time determined  
11 by the Secretary. Initial payments are due in  
12 advance of certification under this part. Pay-  
13 ments shall continue to accrue until a plan's as-  
14 sets are distributed pursuant to a termination  
15 procedure.

16 “(B) PENALTIES FOR FAILURE TO MAKE  
17 PAYMENTS.—If any payment is not made by a  
18 plan when it is due, a late payment charge of  
19 not more than 100 percent of the payment  
20 which was not timely paid shall be payable by  
21 the plan to the Fund.

22 “(C) CONTINUED DUTY OF THE SEC-  
23 RETARY.—The Secretary shall not cease to  
24 carry out the provisions of paragraph (2) on ac-

1 count of the failure of a plan to pay any pay-  
2 ment when due.

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

1           “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

1           “(A) under which an insurer (meeting such  
2           minimum standards as the applicable authority  
3           may prescribe by regulation through negotiated  
4           rulemaking) provides for payment to the plan  
5           with respect to aggregate claims under the plan  
6           in excess of an amount or amounts specified in  
7           such contract;

8           “(B) which is guaranteed renewable; and

9           “(C) which allows for payment of pre-  
10          miums by any third party on behalf of the in-  
11          sured plan.

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

16               “(A) under which an insurer (meeting such  
17               minimum standards as the applicable authority  
18               may prescribe by regulation through negotiated  
19               rulemaking) provides for payment to the plan  
20               with respect to claims under the plan in connec-  
21               tion with a covered individual in excess of an  
22               amount or amounts specified in such contract  
23               in connection with such covered individual;

24               “(B) which is guaranteed renewable; and

1           “(C) which allows for payment of pre-  
2           miums by any third party on behalf of the in-  
3           sured plan.

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

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

15          “(2) which is guaranteed renewable and  
16          noncancellable for any reason (except as the applica-  
17          ble authority may prescribe by regulation through  
18          negotiated rulemaking); and

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

21          “(i) RESERVES.—For purposes of this section, the  
22 term ‘reserves’ means, in connection with an association  
23 health plan, plan assets which meet the fiduciary stand-  
24 ards under part 4 and such additional requirements re-

1 guarding liquidity as the applicable authority may prescribe  
2 through negotiated rulemaking.

3 “(j) SOLVENCY STANDARDS WORKING GROUP.—

4 “(1) IN GENERAL.—Within 90 days after the  
5 date of the enactment of the Small Business Access  
6 and Choice for Entrepreneurs Act of 2007, the ap-  
7 plicable authority shall establish a Solvency Stand-  
8 ards Working Group. In prescribing the initial regu-  
9 lations under this section, the applicable authority  
10 shall take into account the recommendations of such  
11 Working Group.

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

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

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

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

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

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

4           “(F) a representative of 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 through nego-  
23 tiated rulemaking, at 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 through negotiated  
13              rulemaking.

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

24 “(c) FILING NOTICE OF CERTIFICATION WITH  
25 STATES.—A certification granted under this part to an

1 association health plan shall not be effective unless written  
2 notice of such certification is filed with the applicable  
3 State authority of each State in which at least 25 percent  
4 of the participants and beneficiaries under the plan are  
5 located. For purposes of this subsection, an individual  
6 shall be considered to be located in the State in which a  
7 known address of such individual is located or in which  
8 such individual is employed.

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

20       “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
21 SOCIATION HEALTH PLANS.—An association health plan  
22 certified under this part which provides benefit options in  
23 addition to health insurance coverage for such plan year  
24 shall meet the requirements of section 103 by filing an  
25 annual report under such section which shall include infor-

1 mation described in subsection (b)(6) with respect to the  
2 plan year and, notwithstanding section 104(a)(1)(A), shall  
3 be filed with the applicable authority not later than 90  
4 days after the close of the plan year (or on such later date  
5 as may be prescribed by the applicable authority). The ap-  
6 plicable authority may require by regulation through nego-  
7 tiated rulemaking such interim reports as it considers ap-  
8 propriate.

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

22               “(1) are in the aggregate reasonably related to  
23       the experience of the plan and to reasonable expecta-  
24       tions; and

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

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

5 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
6 **MINATION.**

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

11           “(1) not less than 60 days before the proposed  
12 termination date, provides to the participants and  
13 beneficiaries a written notice of intent to terminate  
14 stating that such termination is intended and the  
15 proposed termination date;

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

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

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

1 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
2 **NATION.**

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

1 ommendations. The board shall thereafter report to the  
2 applicable authority, in such form and frequency as the  
3 applicable authority may specify to the board, regarding  
4 corrective action taken by the board until the requirements  
5 of section 806 are met.

6 “(b) MANDATORY TERMINATION.—In any case in  
7 which—

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

16 “(2) the applicable authority determines that  
17 there is a reasonable expectation that the plan will  
18 continue to fail to meet the requirements of section  
19 806,

20 the board of trustees of the plan shall, at the direction  
21 of the applicable authority, terminate the plan and, in the  
22 course of the termination, take such actions as the appli-  
23 cable authority may require, including satisfying any  
24 claims referred to in section 806(a)(2)(B)(iii) and recov-  
25 ering for the plan any liability under subsection

1 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
2 that the affairs of the plan will be, to the maximum extent  
3 possible, wound up in a manner which will result in timely  
4 provision of all benefits for which the plan is obligated.

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

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

1 of the financial condition of the plan. The trusteeship of  
2 such Secretary shall continue until the conditions de-  
3 scribed in the first sentence of this subsection are rem-  
4 edied or the plan is terminated.

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

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

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

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

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

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

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

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

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

16           “(9) to provide for the enrollment of plan par-  
17 ticipants and beneficiaries under appropriate cov-  
18 erage options; and

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

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

4           “(1) the sponsor and plan administrator;

5           “(2) each participant;

6           “(3) each participating employer; and

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

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

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

24          “(f) JURISDICTION OF COURT.—

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

24           “(2) VENUE.—An action under this section  
25          may be brought in the judicial district where the

1 sponsor or the plan administrator resides or does  
2 business or where any asset of the plan is situated.  
3 A district court in which such action is brought may  
4 issue process with respect to such action in any  
5 other judicial district.

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

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

13 “(a) IN GENERAL.—Notwithstanding section 514, a  
14 State may impose by law a contribution tax on an associa-  
15 tion health plan described in section 806(a)(2), if the plan  
16 commenced operations in such State after the date of the  
17 enactment of the Small Business Access and Choice for  
18 Entrepreneurs Act of 2007.

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

23 “(1) such tax is computed by applying a rate to  
24 the amount of premiums or contributions, with re-  
25 spect to individuals covered under the plan who are

1 residents of such State, which are received by the  
2 plan from participating employers located in such  
3 State or from such individuals;

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

10 “(3) such tax is otherwise nondiscriminatory;  
11 and

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

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

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

18       “(b) EFFECT OF ELECTION.—

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

1           “(2) GENERAL STATE INSURANCE REGULATION  
2           UNAFFECTED.—

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

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

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

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

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

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

16           “(c) REQUIREMENTS FOR COVERED CHURCH  
17 PLANS.—

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

22           “(A) for the exclusive purpose of:

23           “(i) providing benefits to participants  
24 and their beneficiaries; and

1                   “(ii) defraying reasonable expenses of  
2                   administering the plan;

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

9                   “(C) in accordance with the documents  
10                  and instruments governing the plan.

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

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

19                         “(A) provide adequate notice in writing to  
20                         any participant or beneficiary whose claim for  
21                         benefits under the plan has been denied, setting  
22                         forth the specific reasons for such denial, writ-  
23                         ten in a manner calculated to be understood by  
24                         the participant;

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

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

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

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

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

21               “(C) identifying the States in which par-  
22               ticipants and beneficiaries under the plan are or  
23               likely will be located during the 1-year period  
24               covered by the statement; and

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

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

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

1 The other provisions of part 5 (except sections 501(a),  
2 503, 512, 514, and 515) shall apply with respect to the  
3 enforcement and administration of this section.

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

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

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

20 **“SEC. 813. 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.—

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

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

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

20           “(B) EXCEPTIONS.—

21           “(i) JOINT AUTHORITIES.—Where  
22 such term appears in section 808(3), sec-  
23 tion 807(e) (in the first instance), section  
24 809(a) (in the second instance), section  
25 809(a) (in the fourth instance), and sec-

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

6           “(ii) REGULATORY AUTHORITIES.—

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

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

25          “(7) INDIVIDUAL MARKET.—

1           “(A) IN GENERAL.—The term ‘individual  
2 market’ means the market for health insurance  
3 coverage offered to individuals other than in  
4 connection with a group health plan.

5           “(B) TREATMENT OF VERY SMALL  
6 GROUPS.—

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

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

23           “(8) PARTICIPATING EMPLOYER.—The term  
24 ‘participating employer’ means, in connection with  
25 an association health plan, any employer, if any indi-

1       vidual who is an employee of such employer, a part-  
2       ner in such employer, or a self-employed individual  
3       who is such employer (or any dependent, as defined  
4       under the terms of the plan, of such individual) is  
5       or was covered under such plan in connection with  
6       the status of such individual as such an employee,  
7       partner, or self-employed individual in relation to the  
8       plan.

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

16              “(10) QUALIFIED ACTUARY.—The term ‘quali-  
17       fied actuary’ means an individual who is a member  
18       of the American Academy of Actuaries or meets  
19       such reasonable standards and qualifications as the  
20       Secretary may provide by regulation through nego-  
21       tiated rulemaking.

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

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

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

8           “(C) in the case of an association health  
9           plan in existence on the date of the enactment  
10          of the Small Business Access and Choice for  
11          Entrepreneurs Act of 2007, a person eligible to  
12          be a member of the sponsor or one of its mem-  
13          ber associations.

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

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

25          “(b) RULES OF CONSTRUCTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 “(3) For additional provisions relating to association  
16 health plans, see subsections (a)(2)(B) and (b) of section  
17 805.

18 “(4) For purposes of this subsection, the term ‘asso-  
19 ciation health plan’ has the meaning provided in section  
20 801(a), and the terms ‘health insurance coverage’, ‘par-  
21 ticipating employer’, and ‘health insurance issuer’ have  
22 the meanings provided such terms in section 811, respec-  
23 tively.”.

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

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

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

8 (C) by adding at the end the following new  
9 clause:

10 “(iii) subject to subparagraph (E), in the case  
11 of any other employee welfare benefit plan which is  
12 a multiple employer welfare arrangement and which  
13 provides medical care (within the meaning of section  
14 733(a)(2)), any law of any State which regulates in-  
15 surance may apply.”.

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

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

21 (B) by adding at the end the following new  
22 paragraph:

23 “(2) Nothing in any other provision of law enacted  
24 on or after the date of the enactment of the Small Busi-  
25 ness Access and Choice for Entrepreneurs Act of 2007

1 shall be construed to alter, amend, modify, invalidate, im-  
2 pair, or supersede any provision of this title, except by  
3 specific cross-reference to the affected section.”.

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

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

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

20 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
21 CATION OF SELF-INSURED ASSOCIATION HEALTH  
22 PLANS.—Not later than January 1, 2010, the Secretary  
23 of Labor shall report to the Committee on Education and  
24 the Workforce of the House of Representatives and the  
25 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

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

7 **SEC. 403. 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 amend-  
11 ed—

12 (1) in clause (i), by inserting “for any plan year  
13 of any such plan, or any fiscal year of any such  
14 other arrangement,” after “single employer”, and by  
15 inserting “during such year or at any time during  
16 the preceding 1-year period” after “control group”;

1 (2) in clause (iii)—

2 (A) by striking “common control shall not  
3 be based on an interest of less than 25 percent”  
4 and inserting “an interest of greater than 25  
5 percent may not be required as the minimum  
6 interest necessary for common control”; and

7 (B) by striking “similar to” and inserting  
8 “consistent and coextensive with”;

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

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

13 “(iv) in determining, after the application of  
14 clause (i), whether benefits are provided to employ-  
15 ees of two or more employers, the arrangement shall  
16 be treated as having only one participating employer  
17 if, after the application of clause (i), the number of  
18 individuals who are employees and former employees  
19 of any one participating employer and who are cov-  
20 ered under the arrangement is greater than 75 per-  
21 cent of the aggregate number of all individuals who  
22 are employees or former employees of participating  
23 employers and who are covered under the arrange-  
24 ment;”.

1 **SEC. 404. CLARIFICATION OF TREATMENT OF CERTAIN**  
2 **COLLECTIVELY BARGAINED ARRANGE-**  
3 **MENTS.**

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

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

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

20 “(C) For purposes of subparagraph (A)(i)(II), a plan  
21 or other arrangement shall be treated as established or  
22 maintained in accordance with this subparagraph only if  
23 the following requirements are met:

24 “(i) The plan or other arrangement, and the  
25 employee organization or any other entity sponsoring  
26 the plan or other arrangement, do not—

1           “(I) utilize the services of any licensed in-  
2           surance agent or broker for soliciting or enroll-  
3           ing employers or individuals as participating  
4           employers or covered individuals under the plan  
5           or other arrangement; or

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

19          except to the extent that the services used by the  
20          plan, arrangement, organization, or other entity con-  
21          sist solely of preparation of documents necessary for  
22          compliance with the reporting and disclosure re-  
23          quirements of part 1 or administrative, investment,  
24          or consulting services unrelated to solicitation or en-  
25          rollment of covered individuals.

1           “(ii) As of the end of the preceding plan year,  
2           the number of covered individuals under the plan or  
3           other arrangement who are neither—

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

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

17           does not exceed 15 percent of the total number of  
18           individuals who are covered under the plan or ar-  
19           rangement and who are present or former employees  
20           who are or were covered under the plan or arrange-  
21           ment pursuant to a collective bargaining agreement  
22           with a participating employer. The requirements of  
23           the preceding provisions of this clause shall be treat-  
24           ed as satisfied if, as of the end of the preceding plan  
25           year, such covered individuals are comprised solely

1 of individuals who were covered individuals under  
2 the plan or other arrangement as of the date of the  
3 enactment of the Small Business Access and Choice  
4 for Entrepreneurs Act of 2003 and, as of the end of  
5 the preceding plan year, the number of such covered  
6 individuals does not exceed 25 percent of the total  
7 number of present and former employees enrolled  
8 under the plan or other arrangement.

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

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

19 “(i) all of the benefits provided under the plan  
20 or arrangement consist of health insurance coverage;  
21 or

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

24 “(II) the requirements of clause (B) of the pro-  
25 viso to clause (5) of section 302(c) of the Labor

1 Management Relations Act, 1947 (29 U.S.C.  
2 186(c)) are met with respect to such plan or other  
3 arrangement.

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

7 “(i) the plan or arrangement is in effect as of  
8 the date of the enactment of the Small Business Ac-  
9 cess and Choice for Entrepreneurs Act of 2007; or

10 “(ii) the employee organization or other entity  
11 sponsoring the plan or arrangement—

12 “(I) has been in existence for at least 3  
13 years; or

14 “(II) demonstrates to the satisfaction of  
15 the Secretary that the requirements of subpara-  
16 graphs (C) and (D) are met with respect to the  
17 plan or other arrangement.”.

18 (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
19 PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
20 Act (29 U.S.C. 1002(7)) is amended by adding at the end  
21 the following new sentence: “Such term includes an indi-  
22 vidual who is a covered individual described in paragraph  
23 (40)(C)(ii).”.

1 **SEC. 405. ENFORCEMENT PROVISIONS.**

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

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

7 (2) by adding at the end the following new sub-  
8 section:

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

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

17 “(2) having been established or maintained  
18 under or pursuant to one or more collective bar-  
19 gaining agreements which are reached pursuant to  
20 collective bargaining described in section 8(d) of the  
21 National Labor Relations Act (29 U.S.C. 158(d)) or  
22 paragraph Fourth of section 2 of the Railway Labor  
23 Act (45 U.S.C. 152, paragraph Fourth) or which are  
24 reached pursuant to labor-management negotiations  
25 under similar provisions of State public employee re-  
26 lations laws; or

1           “(3) being a plan or arrangement with respect  
2           to which the requirements of subparagraph (C), (D),  
3           or (E) of section 3(40) are met;  
4 shall, upon conviction, be imprisoned not more than 5  
5 years, be fined under title 18, United States Code, or  
6 both.”.

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

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

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

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

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

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

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

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

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

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

19               (2) by adding at the end the following new sub-  
20 section:

21       “(b) ASSOCIATION HEALTH PLANS.—The terms of  
22 each association health plan which is or has been certified  
23 under part 8 shall require the board of trustees or the  
24 named fiduciary (as applicable) to ensure that the require-

1 ments of this section are met in connection with claims  
2 filed under the plan.”.

3 **SEC. 406. COOPERATION BETWEEN FEDERAL AND STATE**  
4 **AUTHORITIES.**

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

8 “(d) **RESPONSIBILITY OF STATES WITH RESPECT TO**  
9 **ASSOCIATION HEALTH PLANS.—**

10 “(1) **AGREEMENTS WITH STATES.—**A State  
11 may enter into an agreement with the Secretary for  
12 delegation to the State of some or all of—

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

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

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

23 “(2) **DELEGATIONS.—**Any department, agency,  
24 or instrumentality of a State to which authority is  
25 delegated pursuant to an agreement entered into

1 under this paragraph may, if authorized under State  
2 law and to the extent consistent with such agree-  
3 ment, exercise the powers of the Secretary under  
4 this title which relate to such authority.

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

18 **SEC. 407. EFFECTIVE DATE AND TRANSITIONAL AND**  
19 **OTHER RULES.**

20 (a) **EFFECTIVE DATE.**—The amendments made by  
21 sections 101, 104, and 105 shall take effect on January  
22 1, 2007. The amendments made by sections 102 and 103  
23 shall take effect on the date of the enactment of this Act.  
24 The Secretary of Labor shall first issue all regulations  
25 necessary to carry out the amendments made by this sub-

1 title before January 1, 2007. Such regulations shall be  
2 issued through negotiated rulemaking.

3 (b) EXCEPTION.—Section 801(a)(2) of the Employee  
4 Retirement Income Security Act of 1974 (added by section  
5 101) does not apply in connection with an association  
6 health plan (certified under part 8 of subtitle B of title  
7 I of such Act) existing on the date of the enactment of  
8 this Act, if no benefits provided thereunder as of the date  
9 of the enactment of this Act consist of health insurance  
10 coverage (as defined in section 733(b)(1) of such Act).

11 (c) TREATMENT OF CERTAIN EXISTING HEALTH  
12 BENEFITS PROGRAMS.—

13 (1) IN GENERAL.—In any case in which, as of  
14 the date of the enactment of this Act, an arrange-  
15 ment is maintained in a State for the purpose of  
16 providing benefits consisting of medical care for the  
17 employees and beneficiaries of its participating em-  
18 ployers, at least 200 participating employers make  
19 contributions to such arrangement, such arrange-  
20 ment has been in existence for at least 10 years, and  
21 such arrangement is licensed under the laws of one  
22 or more States to provide such benefits to its par-  
23 ticipating employers, upon the filing with the appli-  
24 cable authority (as defined in section 813(a)(5) of  
25 the Employee Retirement Income Security Act of

1 1974 (as amended by this Act)) by the arrangement  
2 of an application for certification of the arrangement  
3 under part 8 of subtitle B of title I of such Act—

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

7 (B) the requirements of sections 801(a)(1)  
8 and 803(a)(1) of the Employee Retirement In-  
9 come Security Act of 1974 shall be deemed met  
10 with respect to such arrangement;

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

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

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

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

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

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

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

8           (2) DEFINITIONS.—For purposes of this sub-  
9           section, the terms “group health plan”, “medical  
10          care”, and “participating employer” shall have the  
11          meanings provided in section 813 of the Employee  
12          Retirement Income Security Act of 1974, except  
13          that the reference in paragraph (7) of such section  
14          to an “association health plan” shall be deemed a  
15          reference to an arrangement referred to in this sub-  
16          section.

17 **TITLE V—IMPROVEMENT TO AC-**  
18 **CESS AND CHOICE OF**  
19 **HEALTH CARE**

20 **SEC. 501. REFUNDABLE AND ADVANCEABLE CREDIT FOR**  
21 **HEALTH INSURANCE COSTS.**

22          (a) IN GENERAL.—Subpart C of part IV of sub-  
23 chapter A of chapter 1 of the Internal Revenue Code of  
24 1986 (relating to refundable credits) is amended by redес-

1 ignating section 36 as section 37 and by inserting after  
2 section 35 the following new section:

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

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

9       “(b) LIMITATIONS.—

10           “(1) MAXIMUM CREDIT.—

11               “(A) IN GENERAL.—The amount allowed  
12 as a credit under subsection (a) to the taxpayer  
13 for the taxable year shall not exceed the sum of  
14 the monthly limitations for months during such  
15 taxable year.

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

19                   “(i) the product of \$1,000 multiplied  
20 by the number of individuals taken into ac-  
21 count under subsection (a) who are covered  
22 under qualified health insurance as of the  
23 first day of such month; or

24                   “(ii) \$3,000.

1           “(2) EMPLOYER SUBSIDIZED COVERAGE.—Sub-  
2           section (a) shall not apply to amounts paid for cov-  
3           erage of any individual for any month for which  
4           such individual participates in any subsidized health  
5           plan maintained by any employer of the taxpayer or  
6           of the spouse of the taxpayer. The rule of the last  
7           sentence of section 162(l)(2)(B) shall apply for pur-  
8           poses of the preceding sentence.

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

11           “(1) IN GENERAL.—The term ‘qualified health  
12          insurance’ means insurance which constitutes med-  
13          ical care if—

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

16                   “(B) there is no exclusion from, or limita-  
17                   tion on, coverage for any preexisting medical  
18                   condition of any applicant who, on the date the  
19                   application is made, has been continuously in-  
20                   sured during the 1-year period ending on the  
21                   date of the application under—

22                           “(i) qualified health insurance (deter-  
23                           mined without regard to this subpara-  
24                           graph), or

25                           “(ii) a program described in—

1                   “(I) title XVIII or XIX of the  
2                   Social Security Act,

3                   “(II) chapter 55 of title 10,  
4                   United States Code,

5                   “(III) chapter 17 of title 38,  
6                   United States Code,

7                   “(IV) chapter 89 of title 5,  
8                   United States Code, or

9                   “(V) the Indian Health Care Im-  
10                  provement Act, and

11                  “(C) in the case of each applicant who has  
12                  not been continuously so insured during the 1-  
13                  year period ending on the date the application  
14                  is made, the exclusion from, or limitation on,  
15                  coverage for any preexisting medical condition  
16                  does not extend beyond the period after such  
17                  date equal to the lesser of—

18                         “(i) the number of months imme-  
19                         diately prior to such date during which the  
20                         individual was not so insured since the ill-  
21                         ness or condition in question was first di-  
22                         agnosed, or

23                         “(ii) 1 year.

24                  “(2) EXCLUSION OF CERTAIN PLANS.—Such  
25                  term does not include—

1           “(A) insurance if substantially all of its  
2 coverage is coverage described in section  
3 223(c)(1)(B),

4           “(B) insurance under a program described  
5 in paragraph (1)(B)(ii).

6           “(3) TRANSITION RULE FOR 2007.—In the case  
7 of applications made during 2007, the requirements  
8 of subparagraphs (C) and (D) of paragraph (1) are  
9 met only if the insurance does not exclude from cov-  
10 erage, or limit coverage for, any preexisting medical  
11 condition of any applicant.

12          “(d) SPECIAL RULES.—

13           “(1) COORDINATION WITH MEDICAL DEDUC-  
14 TION, ETC.—Any amount paid by a taxpayer for in-  
15 surance to which subsection (a) applies shall not be  
16 taken into account in computing the amount allow-  
17 able to the taxpayer as a credit under section 35 or  
18 as a deduction under section 162(l) or 213(a).

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

1           “(3) MARRIED COUPLES MUST FILE JOINT RE-  
2           TURN.—

3           “(A) IN GENERAL.—If the taxpayer is  
4           married at the close of the taxable year, the  
5           credit shall be allowed under subsection (a) only  
6           if the taxpayer and his spouse file a joint return  
7           for the taxable year.

8           “(B) MARITAL STATUS; CERTAIN MARRIED  
9           INDIVIDUALS LIVING APART.—Rules similar to  
10          the rules of paragraphs (3) and (4) of section  
11          21(e) shall apply for purposes of this para-  
12          graph.

13          “(4) VERIFICATION OF COVERAGE, ETC.—No  
14          credit shall be allowed under this section to any indi-  
15          vidual unless such individual’s coverage under quali-  
16          fied health insurance, and the amount paid for such  
17          coverage, are verified in such manner as the Sec-  
18          retary may prescribe.

19          “(5) COORDINATION WITH ADVANCE PAYMENTS  
20          OF CREDIT.—With respect to any taxable year, the  
21          amount which would (but for this subsection) be al-  
22          lowed as a credit to the taxpayer under subsection  
23          (a) shall be reduced (but not below zero) by the ag-  
24          gregate amount paid on behalf of such taxpayer

1 under section 7527A for months beginning in such  
2 taxable year.

3 “(6) COST-OF-LIVING ADJUSTMENT.—In the  
4 case of any taxable year beginning in a calendar  
5 year after 2007, each dollar amount contained in  
6 subsection (b)(1)(B) shall be increased by an  
7 amount equal to—

8 “(A) such dollar amount, multiplied by

9 “(B) the cost-of-living adjustment deter-  
10 mined under section 1(f)(3) for the calendar  
11 year in which the taxable year begins by sub-  
12 stituting ‘calendar year 2006’ for ‘calendar year  
13 1992’ in subparagraph (B) thereof.

14 Any increase determined under the preceding sen-  
15 tence shall be rounded to the nearest multiple of  
16 \$10.”.

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

21 **“SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH**  
22 **INSURANCE COSTS.**

23 “(a) GENERAL RULE.—The Secretary shall establish  
24 a program for making payments on behalf of individuals

1 to providers of qualified health insurance (as defined in  
2 section 36(c)) for such individuals.

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

11 (c) CONFORMING AMENDMENTS.—

12 (1) Paragraph (2) of section 1324(b) of title  
13 31, United States Code, is amended by inserting “or  
14 36” after “section 35”.

15 (2) The table of sections for subpart C of part  
16 IV of subchapter A of chapter 1 of the Internal Rev-  
17 enue Code of 1986 is amended by striking the item  
18 relating to section 36 and inserting the following  
19 new items:

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

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

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

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2006

4 **SEC. 502. EXCLUSION FOR EMPLOYER PAYMENTS MADE TO**  
5 **COMPENSATE EMPLOYEES WHO ELECT NOT**  
6 **TO PARTICIPATE IN EMPLOYER-SUBSIDIZED**  
7 **HEALTH PLANS.**

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

12 **“SEC. 139B. TREATMENT OF COMPENSATING PAYMENTS**  
13 **MADE FOR EMPLOYEES WHO ELECT NOT TO**  
14 **PARTICIPATE IN EMPLOYER-SUBSIDIZED**  
15 **HEALTH PLANS.**

16 “(a) IN GENERAL.—Gross income of an eligible em-  
17 ployee shall not include the amount of any compensating  
18 coverage payment made by an employer of such employee  
19 for such employee’s benefit.

20 “(b) ELIGIBLE EMPLOYEE.—For purposes of this  
21 section, the term ‘eligible employee’ means any employee  
22 who is eligible to participate in any subsidized health plan  
23 of an employer for any period and who elects not to par-  
24 ticipate in any subsidized health plan of such employer  
25 for such period.

1       “(c) COMPENSATING COVERAGE PAYMENT.—For  
2 purposes of this section, the term ‘compensating coverage  
3 payment’ means—

4           “(1) any payment made by the employer for  
5 qualified health insurance specified by the employee  
6 (for any period for which the employee is described  
7 in subsection (b)) which covers all of the individuals  
8 who, but for the election referred to in subsection  
9 (b), would be covered under the subsidized health  
10 plan of the employer, and

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

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

18       “(e) EMPLOYER PARTICIPATION.—

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

22           “(A) the employer, and all other employers  
23 which are members of any controlled group  
24 which includes such employer, agree to make  
25 such payments to all their eligible employees,

1           “(B) the amount of such payment is not  
2 less than the employer health plan contribution  
3 for such period with respect to the employee,  
4 and

5           “(C) the employer permits the election re-  
6 ferred to in subsection (b) to be made by em-  
7 ployees—

8           “(i) at the commencement of employ-  
9 ment with the employer, and

10           “(ii) during open enrollment periods  
11 (not less frequently than annually) of at  
12 least 30 days.

13           “(2) EXCEPTION FOR CERTAIN EMPLOYEES.—  
14 Paragraph (1) shall not apply to—

15           “(A) any employee who is covered under a  
16 subsidized health plan of another employer of  
17 such employee or of an employer of such em-  
18 ployee’s spouse,

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

21           “(C) any employee who normally works  
22 during not more than 6 months during any  
23 year,

24           “(D) any employee who has not attained  
25 age 21, and

1           “(E) except to the extent provided in regu-  
2           lations, any employee who is included in a unit  
3           of employees covered by an agreement which  
4           the Secretary of Labor finds to be a collective  
5           bargaining agreement between employee rep-  
6           resentatives and the employer.

7           “(3) CONTROLLED GROUPS.—Rules similar to  
8           the rules of subclauses (II) and (III) of paragraph  
9           (4)(D)(iii) shall apply for purposes of paragraph  
10          (1)(A).

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

13               “(A) IN GENERAL.—The term ‘employer  
14               health plan contribution’ means the applicable  
15               premium for the employee reduced by the em-  
16               ployee’s share of such premium.

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

21                       “(i) the applicable premium (as de-  
22                       fined in section 4980B(f)(4)) for the em-  
23                       ployee, or

24                       “(ii) if an election under subpara-  
25                       graph (D) is in effect with respect to an

1 employee, the applicable premium deter-  
2 mined under subparagraph (D).

3 “(C) EMPLOYEE’S SHARE.—The term ‘em-  
4 ployee’s share’ means, with respect to the appli-  
5 cable premium for any employee, the amount of  
6 the cost to the plan which is paid by the simi-  
7 larly situated beneficiaries who are taken into  
8 account in determining such premium for such  
9 employee.

10 “(D) AUTHORITY TO USE AGE, SEX, AND  
11 GEOGRAPHY IN DETERMINING CONTRIBU-  
12 TION.—

13 “(i) IN GENERAL.—An employer may  
14 elect to determine the applicable premium  
15 for an employee on an actuarial basis tak-  
16 ing into account age, sex, and geography of  
17 the employee and similarly situated bene-  
18 ficiaries.

19 “(ii) DETERMINATION OF EM-  
20 PLOYEE’S SHARE.—In the case of an em-  
21 ployer who determines the applicable pre-  
22 mium under clause (i), the employee’s  
23 share of such premium shall be the same  
24 percentage of such premium as the employ-

1 ee's share of the applicable premium deter-  
2 mined without regard to clause (i).

3 “(iii) CONSISTENCY REQUIRED.—

4 “(I) IN GENERAL.—Except as  
5 provided in subclause (III), an em-  
6 ployer may determine the applicable  
7 premium under this subparagraph for  
8 any employee only if such employer,  
9 and all other employers which are  
10 members of any controlled group  
11 which includes such employer, elect to  
12 determine the applicable premium  
13 under this subparagraph for all their  
14 employees.

15 “(II) CONTROLLED GROUP.—All  
16 persons treated as a single employer  
17 under subsection (a) or (b) of section  
18 52 or subsection (m) or (o) of section  
19 414 shall be treated as members of a  
20 controlled group for purposes of sub-  
21 clause (I).

22 “(III) TREATMENT OF SEPARATE  
23 LINES OF BUSINESS.—If an employer  
24 is treated under section 414(r) as op-  
25 erating separate lines of business dur-

1                   ing any taxable year, subclause (I)  
2                   shall not apply to employees employed  
3                   in such separate lines of business.

4           “(f) SPECIAL RULE FOR ARCHER MSAS AND  
5 HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—Sections  
6 220(b)(5) and 223(b)(4) shall not apply to an employer  
7 contribution which is excludable from gross income under  
8 subsection (a).

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

13           (b) EMPLOYER HEALTH PLAN CONTRIBUTION TO  
14 BE REPORTED ON W-2.—Subsection (a) of section 6051  
15 of such Code (relating to receipts to employees) is amend-  
16 ed by striking “and” at the end of paragraph (12), by  
17 striking the period at the end of paragraph (13) and in-  
18 serting a comma, and by inserting after paragraph (13)  
19 the following new paragraphs:

20                   “(14) the amount of the employer health plan  
21                   contribution (as defined in section 139(c)(3)), and

22                   “(15) the amount of compensating coverage  
23                   payment (as defined in section 139(e)(1)).”.

1 (c) CLERICAL AMENDMENT.—The table of sections  
 2 for such part III is amended by inserting after the item  
 3 relating to section 139A the following new item:

“Sec. 139B. Treatment of compensating payments made for employees who  
 elect not to participate in employer-subsidized health plans.”.

4 (d) EFFECTIVE DATE.—The amendments made by  
 5 this section shall apply to taxable years beginning after  
 6 December 31, 2007.

7 **TITLE VI—PATIENT ACCESS TO**  
 8 **INFORMATION**

9 **SEC. 601. PATIENT ACCESS TO INFORMATION REGARDING**  
 10 **PLAN COVERAGE, MANAGED CARE PROCE-**  
 11 **DURES, HEALTH CARE PROVIDERS, AND**  
 12 **QUALITY OF MEDICAL CARE.**

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

16 **“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARD-**  
 17 **ING PLAN COVERAGE, MANAGED CARE PRO-**  
 18 **CEDURES, HEALTH CARE PROVIDERS, AND**  
 19 **QUALITY OF MEDICAL CARE.**

20 “(a) DISCLOSURE REQUIREMENT.—Each health in-  
 21 surance issuer offering health insurance coverage in con-  
 22 nection with a group health plan shall provide the adminis-  
 23 trator of such plan on a timely basis with the information  
 24 necessary to enable the administrator to include in the

1 summary plan description of the plan required under sec-  
2 tion 102 of the Employee Retirement Income Security Act  
3 of 1974 (or each summary plan description in any case  
4 in which different summary plan descriptions are appro-  
5 priate under part 1 of subtitle B of title I of such Act  
6 for different options of coverage) the information required  
7 under subsections (b), (c), (d), and (e)(2)(A). To the ex-  
8 tent that any such issuer provides such information on a  
9 timely basis to plan participants and beneficiaries, the re-  
10 quirements of this subsection shall be deemed satisfied in  
11 the case of such plan with respect to such information.

12 “(b) PLAN BENEFITS.—The information required  
13 under subsection (a) includes the following:

14 “(1) COVERED ITEMS AND SERVICES.—

15 “(A) CATEGORIZATION OF INCLUDED BEN-  
16 EFITS.—A description of covered benefits, cat-  
17 egorized by—

18 “(i) types of items and services (in-  
19 cluding any special disease management  
20 program); and

21 “(ii) types of health care professionals  
22 providing such items and services.

23 “(B) EMERGENCY MEDICAL CARE.—A de-  
24 scription of the extent to which the coverage in-  
25 cludes emergency medical care (including the

1 extent to which the coverage provides for access  
2 to urgent care centers), and any definitions pro-  
3 vided under in connection with such coverage  
4 for the relevant coverage terminology referring  
5 to such care.

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

9 “(D) DRUG FORMULARIES.—A description  
10 of the extent to which covered benefits are de-  
11 termined by the use or application of a drug  
12 formulary and a summary of the process for de-  
13 termining what is included in such formulary.

14 “(E) COBRA CONTINUATION COV-  
15 ERAGE.—A description of the benefits available  
16 under the coverage provided pursuant to part 6  
17 of subtitle B of title I of the Employee Retire-  
18 ment Income Security Act of 1974.

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

21 “(A) CATEGORIZATION OF EXCLUDED  
22 BENEFITS.—A description of benefits specifi-  
23 cally excluded from coverage, categorized by  
24 types of items and services.

1           “(B) UTILIZATION REVIEW AND  
2           PREAUTHORIZATION REQUIREMENTS.—Whether  
3           coverage for medical care is limited or excluded  
4           on the basis of utilization review or  
5           preauthorization requirements.

6           “(C) LIFETIME, ANNUAL, OR OTHER PE-  
7           RIOD LIMITATIONS.—A description of the cir-  
8           cumstances under which, and the extent to  
9           which, coverage is subject to lifetime, annual, or  
10          other period limitations, categorized by types of  
11          benefits.

12          “(D) CUSTODIAL CARE.—A description of  
13          the circumstances under which, and the extent  
14          to which, the coverage of benefits for custodial  
15          care is limited or excluded, and a statement of  
16          the definition used in connection with such cov-  
17          erage for custodial care.

18          “(E) EXPERIMENTAL TREATMENTS.—  
19          Whether coverage for any medical care is lim-  
20          ited or excluded because it constitutes experi-  
21          mental treatment or technology, and any defini-  
22          tions provided in connection with such coverage  
23          for the relevant plan terminology referring to  
24          such limited or excluded care.

1           “(F) MEDICAL APPROPRIATENESS OR NE-  
2           CESSITY.—Whether coverage for medical care  
3           may be limited or excluded by reason of a fail-  
4           ure to meet the plan’s requirements for medical  
5           appropriateness or necessity, and any defini-  
6           tions provided in connection with such coverage  
7           for the relevant coverage terminology referring  
8           to such limited or excluded care.

9           “(G) SECOND OR SUBSEQUENT OPIN-  
10          IONS.—A description of the circumstances  
11          under which, and the extent to which, coverage  
12          for second or subsequent opinions is limited or  
13          excluded.

14          “(H) SPECIALTY CARE.—A description of  
15          the circumstances under which, and the extent  
16          to which, coverage of benefits for specialty care  
17          is conditioned on referral from a primary care  
18          provider.

19          “(I) CONTINUITY OF CARE.—A description  
20          of the circumstances under which, and the ex-  
21          tent to which, coverage of items and services  
22          provided by any health care professional is lim-  
23          ited or excluded by reason of the departure by  
24          the professional from any defined set of pro-  
25          viders.

1           “(J) RESTRICTIONS ON COVERAGE OF  
2           EMERGENCY SERVICES.—A description of the  
3           circumstances under which, and the extent to  
4           which, the coverage, in including emergency  
5           medical care furnished to a participant or bene-  
6           ficiary of the plan imposes any financial respon-  
7           sibility described in subsection (e) on partici-  
8           pants or beneficiaries or limits or conditions  
9           benefits for such care subject to any other term  
10          or condition of such coverage.

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

14           “(1) a participant’s financial responsibility for  
15           payment of premiums, coinsurance, copayments,  
16           deductibles, and any other charges; and

17           “(2) the circumstances under which, and the  
18           extent to which, the participant’s financial responsi-  
19           bility described in paragraph (1) may vary, including  
20           any distinctions based on whether a health care pro-  
21           vider from whom covered benefits are obtained is in-  
22           cluded in a defined set of providers.

23          “(d) ACCOUNTABILITY.—The information required  
24          under subsection (a) includes a description of the legal re-

1 course options available for participants and beneficiaries  
2 under the plan including—

3 “(1) the preemption that applies under section  
4 514 of the Employee Retirement Income Security  
5 Act of 1974 (29 U.S.C. 1144) to certain actions  
6 arising out of the provision of health benefits;

7 “(2) the ability of a participant or beneficiary  
8 (or the estate of the participant or beneficiary)  
9 under State law to recover damages resulting from  
10 personal injury or for wrongful death against any  
11 person in connection with the provision of insurance,  
12 administrative services, or medical services by such  
13 person to or for a group health plan; and

14 “(3) the extent to which coverage decisions  
15 made by the plan are subject to internal review or  
16 any external review and the proper time frames  
17 under which such reviews may be requested and con-  
18 ducted.

19 “(e) INFORMATION AVAILABLE ON REQUEST.—

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

22 “(A) IN GENERAL.—A group health plan  
23 (and a health insurance issuer offering health  
24 insurance coverage in connection with a group  
25 health plan) shall, upon written request (made

1 not more frequently than annually), make avail-  
2 able to participants and beneficiaries, in a gen-  
3 erally recognized electronic format, the fol-  
4 lowing information:

5 “(i) the latest summary plan descrip-  
6 tion, including the latest summary of ma-  
7 terial modifications; and

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

19 “(B) ALTERNATIVE ACCESS.—The require-  
20 ments of this paragraph may be met by making  
21 such information generally available (rather  
22 than upon request) on the Internet or on a pro-  
23 prietary computer network in a format which is  
24 readily accessible to participants and bene-  
25 ficiaries.

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

3           “(A) INCLUSION IN SUMMARY PLAN DE-  
4           SCRIPTION OF SUMMARY OF ADDITIONAL IN-  
5           FORMATION.—The information required under  
6           subsection (a) includes a summary description  
7           of the types of information required by this  
8           subsection to be made available to participants  
9           and beneficiaries on request.

10          “(B) INFORMATION REQUIRED FROM  
11          PLANS AND ISSUERS ON REQUEST.—In addition  
12          to information required to be included in sum-  
13          mary plan descriptions under this subsection, a  
14          group health plan (and a health insurance  
15          issuer offering health insurance coverage in  
16          connection with a group health plan) shall pro-  
17          vide the following information to a participant  
18          or beneficiary on request:

19                 “(i) NETWORK CHARACTERISTICS.—If  
20                 the plan (or issuer) utilizes a defined set of  
21                 providers under contract with the plan (or  
22                 issuer), a detailed list of the names of such  
23                 providers and their geographic location, set  
24                 forth separately with respect to primary

1 care providers and with respect to special-  
2 ists.

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

13 “(iii) INCLUSION OF DRUGS AND  
14 BIOLOGICALS IN FORMULARIES.—A state-  
15 ment of whether a specific drug or biologi-  
16 cal is included in a formulary used to de-  
17 termine benefits under the plan and a de-  
18 scription of the procedures for considering  
19 requests for any patient-specific waivers.

20 “(iv) PROCEDURES FOR DETERMINING  
21 EXCLUSIONS BASED ON MEDICAL NECES-  
22 SITY OR EXPERIMENTAL TREATMENTS.—  
23 Upon receipt by the participant or bene-  
24 ficiary of any notification of an adverse  
25 coverage decision based on a determination

1 relating to medical necessity or an experi-  
2 mental treatment or technology, a descrip-  
3 tion of the procedures and medically based  
4 criteria used in such decision.

5 “(v) PREAUTHORIZATION AND UTILI-  
6 ZATION REVIEW PROCEDURES.—Upon re-  
7 ceipt by the participant or beneficiary of  
8 any notification of an adverse coverage de-  
9 cision, a description of the basis on which  
10 any preauthorization requirement or any  
11 utilization review requirement has resulted  
12 in such decision.

13 “(vi) ACCREDITATION STATUS OF  
14 HEALTH INSURANCE ISSUERS AND SERV-  
15 ICE PROVIDERS.—A description of the ac-  
16 creditation and licensing status (if any) of  
17 each health insurance issuer offering  
18 health insurance coverage in connection  
19 with the plan and of any utilization review  
20 organization utilized by the issuer or the  
21 plan, together with the name and address  
22 of the accrediting or licensing authority.

23 “(vii) MEASURES OF ENROLLEE SAT-  
24 ISFACTION.—The latest information (if  
25 any) maintained by the plan, or by any

1 health insurance issuer offering health in-  
2 surance coverage in connection with the  
3 plan, relating to enrollee satisfaction.

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

14 “(C) INFORMATION REQUIRED FROM  
15 HEALTH CARE PROFESSIONALS ON REQUEST.—  
16 Any health care professional treating a partici-  
17 pant or beneficiary under a group health plan  
18 shall provide to the participant or beneficiary,  
19 on request, a description of his or her profes-  
20 sional qualifications (including board certifi-  
21 cation status, licensing status, and accreditation  
22 status, if any), privileges, and experience and a  
23 general description by category (including sal-  
24 ary, fee-for-service, capitation, and such other  
25 categories as may be specified in regulations of

1 the Secretary) of the applicable method by  
2 which such professional is compensated in con-  
3 nection with the provision of such medical care.

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

14 “(f) ACCESS TO INFORMATION RELEVANT TO THE  
15 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT  
16 OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition  
17 to information otherwise required to be made available  
18 under this section, a group health plan (and a health in-  
19 surance issuer offering health insurance coverage in con-  
20 nection with a group health plan) shall, upon written re-  
21 quest (made not more frequently than annually), make  
22 available to a participant (and an employee who, under  
23 the terms of the plan, is eligible for coverage but not en-  
24 rolled) in connection with a period of enrollment the sum-  
25 mary plan description for any coverage option under the

1 plan under which the participant is eligible to enroll and  
2 any information described in clauses (i), (ii), (iii), (vi),  
3 (vii), and (viii) of subsection (e)(2)(B).

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

12 “(1) by inclusion of information in publications  
13 broadly distributed by plan sponsors, employers, or  
14 employee organizations;

15 “(2) by electronic means of communication (in-  
16 cluding the Internet or proprietary computer net-  
17 works in a format which is readily accessible to par-  
18 ticipants);

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

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

1 **SEC. 602. EFFECTIVE DATE.**

2 (a) IN GENERAL.—The amendments made by section  
3 601 shall apply with respect to plan years beginning on  
4 or after January 1 of the second calendar year following  
5 the date of the enactment of this Act. The Secretary shall  
6 first issue all regulations necessary to carry out the  
7 amendments made by section 601 before such date.

8 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
9 enforcement action shall be taken, pursuant to the amend-  
10 ments made by section 601, against a group health plan  
11 or health insurance issuer with respect to a violation of  
12 a requirement imposed by such amendments before the  
13 date of issuance of final regulations issued in connection  
14 with such requirement, if the plan or issuer has sought  
15 to comply in good faith with such requirement.

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