

AMENDMENTS TO H.R. 2563

**OFFERED BY MR. FLETCHER OF KENTUCKY, MR.
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MR. LUCAS OF KENTUCKY**

Insert before section 401 the following heading (and
conform the table of contents accordingly):

1 **Subtitle A—General Provisions**

In section 301(a), insert “subtitle A of” before “title
IV”.

Add at the end of title IV the following new subtitle
(and conform the table of contents accordingly):

2 **Subtitle B—Association Health**
3 **Plans**

4 **SEC. 421. RULES GOVERNING ASSOCIATION HEALTH**
5 **PLANS.**

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



1 “PART 8—RULES GOVERNING ASSOCIATION HEALTH
2 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 plan
6 whose sponsor is (or is deemed under this part to be) de-
7 scribed in subsection (b).

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

10 “(1) is organized and maintained in good faith,
11 with a constitution and bylaws specifically stating its
12 purpose and providing for periodic meetings on at
13 least an annual basis, as a bona fide trade associa-
14 tion, a bona fide industry association (including a
15 rural electric cooperative association or a rural tele-
16 phone cooperative association), a bona fide profes-
17 sional association, or a bona fide chamber of com-
18 merce (or similar bona fide business association, in-
19 cluding a corporation or similar organization that
20 operates on a cooperative basis (within the meaning
21 of section 1381 of the Internal Revenue Code of
22 1986)), for substantial purposes other than that of
23 obtaining or providing medical care;

24 “(2) is established as a permanent entity which
25 receives the active support of its members and re-



1 quires for membership payment on a periodic basis
2 of dues or payments necessary to maintain eligibility
3 for membership in the sponsor; and

4 “(3) does not condition membership, such dues
5 or payments, or coverage under the plan on the
6 basis of health status-related factors with respect to
7 the employees of its members (or affiliated mem-
8 bers), or the dependents of such employees, and does
9 not condition such dues or payments on the basis of
10 group health plan participation.

11 Any sponsor consisting of an association of entities which
12 meet the requirements of paragraphs (1), (2), and (3)
13 shall be deemed to be a sponsor described in this sub-
14 section.

15 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
16 **PLANS.**

17 “(a) IN GENERAL.—The applicable authority shall
18 prescribe by regulation, through negotiated rulemaking, a
19 procedure under which, subject to subsection (b), the ap-
20 plicable authority shall certify association health plans
21 which apply for certification as meeting the requirements
22 of this part.

23 “(b) STANDARDS.—Under the procedure prescribed
24 pursuant to subsection (a), in the case of an association
25 health plan that provides at least one benefit option which

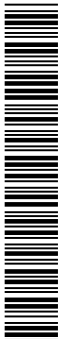


1 does not consist of health insurance coverage, the applica-
2 ble authority shall certify such plan as meeting the re-
3 quirements of this part only if the applicable authority is
4 satisfied that the applicable requirements of this part are
5 met (or, upon the date on which the plan is to commence
6 operations, will be met) with respect to the plan.

7 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
8 PLANS.—An association health plan with respect to which
9 certification under this part is in effect shall meet the ap-
10 plicable requirements of this part, effective on the date
11 of certification (or, if later, on the date on which the plan
12 is to commence operations).

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

17 “(e) CLASS CERTIFICATION FOR FULLY INSURED
18 PLANS.—The applicable authority shall establish a class
19 certification procedure for association health plans under
20 which all benefits consist of health insurance coverage.
21 Under such procedure, the applicable authority shall pro-
22 vide for the granting of certification under this part to
23 the plans in each class of such association health plans
24 upon appropriate filing under such procedure in connec-



1 tion with plans in such class and payment of the pre-
2 scribed fee under section 807(a).

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

8 “(1) a plan which offered such coverage on the
9 date of the enactment of the Bipartisan Patient Pro-
10 tection Act,

11 “(2) a plan under which the sponsor does not
12 restrict membership to one or more trades and busi-
13 nesses or industries and whose eligible participating
14 employers represent a broad cross-section of trades
15 and businesses or industries, or

16 “(3) a plan whose eligible participating employ-
17 ers represent one or more trades or businesses, or
18 one or more industries, consisting of any of the fol-
19 lowing: agriculture; equipment and automobile deal-
20 erships; barbering and cosmetology; certified public
21 accounting practices; child care; construction; dance,
22 theatrical and orchestra productions; disinfecting
23 and pest control; financial services; fishing;
24 foodservice establishments; hospitals; labor organiza-
25 tions; logging; manufacturing (metals); mining; med-



1 ical and dental practices; medical laboratories; pro-
2 fessional consulting services; sanitary services; trans-
3 portation (local and freight); warehousing; whole-
4 saling/distributing; or any other trade or business or
5 industry which has been indicated as having average
6 or above-average risk or health claims experience by
7 reason of State rate filings, denials of coverage, pro-
8 posed premium rate levels, or other means dem-
9 onstrated by such plan in accordance with regula-
10 tions which the Secretary shall prescribe through ne-
11 gotiated rulemaking.

12 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
13 **BOARDS OF TRUSTEES.**

14 “(a) SPONSOR.—The requirements of this subsection
15 are met with respect to an association health plan if the
16 sponsor has met (or is deemed under this part to have
17 met) the requirements of section 801(b) for a continuous
18 period of not less than 3 years ending with the date of
19 the application for certification under this part.

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

23 “(1) FISCAL CONTROL.—The plan is operated,
24 pursuant to a trust agreement, by a board of trust-
25 ees which has complete fiscal control over the plan



1 and which is responsible for all operations of the
2 plan.

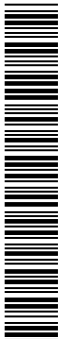
3 “(2) RULES OF OPERATION AND FINANCIAL
4 CONTROLS.—The board of trustees has in effect
5 rules of operation and financial controls, based on a
6 3-year plan of operation, adequate to carry out the
7 terms of the plan and to meet all requirements of
8 this title applicable to the plan.

9 “(3) RULES GOVERNING RELATIONSHIP TO
10 PARTICIPATING EMPLOYERS AND TO CONTRAC-
11 TORS.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraphs (B) and (C), the members of the
14 board of trustees are individuals selected from
15 individuals who are the owners, officers, direc-
16 tors, or employees of the participating employ-
17 ers or who are partners in the participating em-
18 ployers and actively participate in the business.

19 “(B) LIMITATION.—

20 “(i) GENERAL RULE.—Except as pro-
21 vided in clauses (ii) and (iii), no such
22 member is an owner, officer, director, or
23 employee of, or partner in, a contract ad-
24 ministrator or other service provider to the
25 plan.



1 “(ii) LIMITED EXCEPTION FOR PRO-
2 VIDERS OF SERVICES SOLELY ON BEHALF
3 OF THE SPONSOR.—Officers or employees
4 of a sponsor which is a service provider
5 (other than a contract administrator) to
6 the plan may be members of the board if
7 they constitute not more than 25 percent
8 of the membership of the board and they
9 do not provide services to the plan other
10 than on behalf of the sponsor.

11 “(iii) TREATMENT OF PROVIDERS OF
12 MEDICAL CARE.—In the case of a sponsor
13 which is an association whose membership
14 consists primarily of providers of medical
15 care, clause (i) shall not apply in the case
16 of any service provider described in sub-
17 paragraph (A) who is a provider of medical
18 care under the plan.

19 “(C) CERTAIN PLANS EXCLUDED.—Sub-
20 paragraph (A) shall not apply to an association
21 health plan which is in existence on the date of
22 the enactment of the Bipartisan Patient Protec-
23 tion Act.

24 “(D) SOLE AUTHORITY.—The board has
25 sole authority under the plan to approve appli-



1 cations for participation in the plan and to con-
2 tract with a service provider to administer the
3 day-to-day affairs of the plan.

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

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

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

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

21 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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



1 “(B) the joint board of trustees shall be
2 deemed a board of trustees with respect to
3 which the requirements of subsection (b) are
4 met; and

5 “(C) the requirements of section 804 shall
6 be deemed met.

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

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

10 “(B) the plan is in existence on April 1,
11 2001, and would be described in section
12 3(40)(A)(i) but solely for the failure to meet
13 the requirements of section 3(40)(C)(ii).

14 “(3) CONSTRUCTION.—A group health plan de-
15 scribed in paragraph (2) shall only be treated as an
16 association health plan under this part if the spon-
17 sor of the plan applies for, and obtains, certification
18 of the plan as an association health plan under this
19 part.

20 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
21 **MENTS.**

22 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
23 requirements of this subsection are met with respect to
24 an association health plan if, under the terms of the
25 plan—



1 “(1) each participating employer must be—

2 “(A) a member of the sponsor,

3 “(B) the sponsor, or

4 “(C) an affiliated member of the sponsor
5 with respect to which the requirements of sub-
6 section (b) are met,

7 except that, in the case of a sponsor which is a pro-
8 fessional association or other individual-based asso-
9 ciation, if at least one of the officers, directors, or
10 employees of an employer, or at least one of the in-
11 dividuals who are partners in an employer and who
12 actively participates in the business, is a member or
13 such an affiliated member of the sponsor, partici-
14 pating employers may also include such employer;
15 and

16 “(2) all individuals commencing coverage under
17 the plan after certification under this part must
18 be—

19 “(A) active or retired owners (including
20 self-employed individuals), officers, directors, or
21 employees of, or partners in, participating em-
22 ployers; or

23 “(B) the beneficiaries of individuals de-
24 scribed in subparagraph (A).

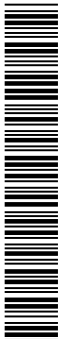


1 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
2 PLOYEES.—In the case of an association health plan in
3 existence on the date of the enactment of the Bipartisan
4 Patient Protection Act, an affiliated member of the spon-
5 sor of the plan may be offered coverage under the plan
6 as a participating employer only if—

7 “(1) the affiliated member was an affiliated
8 member on the date of certification under this part;
9 or

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

16 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
17 quirements of this subsection are met with respect to an
18 association health plan if, under the terms of the plan,
19 no participating employer may provide health insurance
20 coverage in the individual market for any employee not
21 covered under the plan which is similar to the coverage
22 contemporaneously provided to employees of the employer
23 under the plan, if such exclusion of the employee from cov-
24 erage under the plan is based on a health status-related
25 factor with respect to the employee and such employee



1 would, but for such exclusion on such basis, be eligible
2 for coverage under the plan.

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

7 “(1) under the terms of the plan, all employers
8 meeting the preceding requirements of this section
9 are eligible to qualify as participating employers for
10 all geographically available coverage options, unless,
11 in the case of any such employer, participation or
12 contribution requirements of the type referred to in
13 section 2711 of the Public Health Service Act are
14 not met;

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

18 “(3) the applicable requirements of sections
19 701, 702, and 703 are met with respect to the plan.

20 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
21 **DOCUMENTS, CONTRIBUTION RATES, AND**
22 **BENEFIT OPTIONS.**

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



1 “(1) CONTENTS OF GOVERNING INSTRU-
2 MENTS.—The instruments governing the plan in-
3 clude a written instrument, meeting the require-
4 ments of an instrument required under section
5 402(a)(1), which—

6 “(A) provides that the board of trustees
7 serves as the named fiduciary required for plans
8 under section 402(a)(1) and serves in the ca-
9 pacity of a plan administrator (referred to in
10 section 3(16)(A));

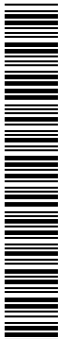
11 “(B) provides that the sponsor of the plan
12 is to serve as plan sponsor (referred to in sec-
13 tion 3(16)(B)); and

14 “(C) incorporates the requirements of sec-
15 tion 806.

16 “(2) CONTRIBUTION RATES MUST BE NON-
17 DISCRIMINATORY.—

18 “(A) The contribution rates for any par-
19 ticipating small employer do not vary on the
20 basis of the claims experience of such employer
21 and do not vary on the basis of the type of
22 business or industry in which such employer is
23 engaged.

24 “(B) Nothing in this title or any other pro-
25 vision of law shall be construed to preclude an



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

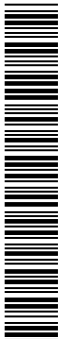
5 “(i) setting contribution rates based
6 on the claims experience of the plan; or

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

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

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

23
24
25 “(4) MARKETING REQUIREMENTS.—



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

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

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

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



1 fined in section 514(c)(1)) shall be construed to preclude
2 an association health plan, or a health insurance issuer
3 offering health insurance coverage in connection with an
4 association health plan, from exercising its sole discretion
5 in selecting the specific items and services consisting of
6 medical care to be included as benefits under such plan
7 or coverage, except (subject to section 514) in the case
8 of any law to the extent that it (1) prohibits an exclusion
9 of a specific disease from such coverage, or (2) is not pre-
10 empted under section 731(a)(1) with respect to matters
11 governed by section 711 or 712.

12 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
13 **FOR SOLVENCY FOR PLANS PROVIDING**
14 **HEALTH BENEFITS IN ADDITION TO HEALTH**
15 **INSURANCE COVERAGE.**

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

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

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

23 “(A) establishes and maintains reserves
24 with respect to such additional benefit options,



1 in amounts recommended by the qualified actu-
2 ary, consisting of—

3 “(i) a reserve sufficient for unearned
4 contributions;

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

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

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

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

22 “(i) The plan shall secure aggregate
23 excess/stop loss insurance for the plan
24 with an attachment point which is not
25 greater than 125 percent of expected gross



1 annual claims. The applicable authority
2 may by regulation, through negotiated
3 rulemaking, provide for upward adjust-
4 ments in the amount of such percentage in
5 specified circumstances in which the plan
6 specifically provides for and maintains re-
7 serves in excess of the amounts required
8 under subparagraph (A).

9 “(ii) The plan shall secure specific ex-
10 cess/stop loss insurance for the plan with
11 an attachment point which is at least equal
12 to an amount recommended by the plan’s
13 qualified actuary. The applicable authority
14 may by regulation, through negotiated
15 rulemaking, provide for adjustments in the
16 amount of such insurance in specified cir-
17 cumstances in which the plan specifically
18 provides for and maintains reserves in ex-
19 cess of the amounts required under sub-
20 paragraph (A).

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



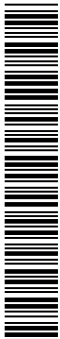
1 Any regulations prescribed by the applicable authority
2 pursuant to clause (i) or (ii) of subparagraph (B) may
3 allow for such adjustments in the required levels of excess/
4 stop loss insurance as the qualified actuary may rec-
5 ommend, taking into account the specific circumstances
6 of the plan.

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

12 “(1) \$500,000, or

13 “(2) such greater amount (but not greater than
14 \$2,000,000) as may be set forth in regulations pre-
15 scribed by the applicable authority through nego-
16 tiated rulemaking, based on the level of aggregate
17 and specific excess/stop loss insurance provided with
18 respect to such plan.

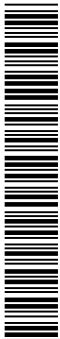
19 “(c) ADDITIONAL REQUIREMENTS.—In the case of
20 any association health plan described in subsection (a)(2),
21 the applicable authority may provide such additional re-
22 quirements relating to reserves and excess/stop loss insur-
23 ance as the applicable authority considers appropriate.
24 Such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



1 negotiated rulemaking, with respect to any such plan or
2 any class of such plans.

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

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



1 of participating employers, security, or other financial ar-
2 rangement.

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

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

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

24 “(B) PENALTIES FOR FAILURE TO MAKE
25 PAYMENTS.—If any payment is not made by a



1 plan when it is due, a late payment charge of
2 not more than 100 percent of the payment
3 which was not timely paid shall be payable by
4 the plan to the Fund.

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

10 “(2) PAYMENTS BY SECRETARY TO CONTINUE
11 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
12 DEMNIFICATION INSURANCE COVERAGE FOR CER-
13 TAIN PLANS.—In any case in which the applicable
14 authority determines that there is, or that there is
15 reason to believe that there will be: (A) a failure to
16 take necessary corrective actions under section
17 809(a) with respect to an association health plan de-
18 scribed in subsection (a)(2); or (B) a termination of
19 such a plan under section 809(b) or 810(b)(8) (and,
20 if the applicable authority is not the Secretary, cer-
21 tifies such determination to the Secretary), the Sec-
22 retary shall determine the amounts necessary to
23 make payments to an insurer (designated by the
24 Secretary) to maintain in force excess/stop loss in-
25 surance coverage or indemnification insurance cov-



1 erage for such plan, if the Secretary determines that
2 there is a reasonable expectation that, without such
3 payments, claims would not be satisfied by reason of
4 termination of such coverage. The Secretary shall, to
5 the extent provided in advance in appropriation
6 Acts, pay such amounts so determined to the insurer
7 designated by the Secretary.

8 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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



1 “(g) EXCESS/STOP LOSS INSURANCE.—For pur-
2 poses of this section—

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

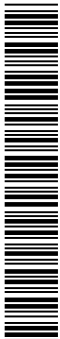
7 “(A) under which an insurer (meeting such
8 minimum standards as the applicable authority
9 may prescribe by regulation through negotiated
10 rulemaking) provides for payment to the plan
11 with respect to aggregate claims under the plan
12 in excess of an amount or amounts specified in
13 such contract;

14 “(B) which is guaranteed renewable; and

15 “(C) which allows for payment of pre-
16 miums by any third party on behalf of the in-
17 sured plan.

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

22 “(A) under which an insurer (meeting such
23 minimum standards as the applicable authority
24 may prescribe by regulation through negotiated
25 rulemaking) provides for payment to the plan



1 with respect to claims under the plan in connec-
2 tion with a covered individual in excess of an
3 amount or amounts specified in such contract
4 in connection with such covered individual;

5 “(B) which is guaranteed renewable; and

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

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

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

20 “(2) which is guaranteed renewable and
21 noncancellable for any reason (except as the applica-
22 ble authority may prescribe by regulation through
23 negotiated rulemaking); and

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



1 “(i) RESERVES.—For purposes of this section, the
2 term ‘reserves’ means, in connection with an association
3 health plan, plan assets which meet the fiduciary stand-
4 ards under part 4 and such additional requirements re-
5 garding liquidity as the applicable authority may prescribe
6 through negotiated rulemaking.

7 “(j) SOLVENCY STANDARDS WORKING GROUP.—

8 “(1) IN GENERAL.—Within 90 days after the
9 date of the enactment of the Bipartisan Patient Pro-
10 tection Act, the applicable authority shall establish a
11 Solvency Standards Working Group. In prescribing
12 the initial regulations under this section, the applica-
13 ble authority shall take into account the rec-
14 ommendations of such Working Group.

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

21 “(A) a representative of the National Asso-
22 ciation of Insurance Commissioners;

23 “(B) a representative of the American
24 Academy of Actuaries;



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

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

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

8 “(F) a representative of multiemployer
9 plans that are group health plans, or their in-
10 terests.

11 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
12 **LATED REQUIREMENTS.**

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

22 “(b) INFORMATION TO BE INCLUDED IN APPLICA-
23 TION FOR CERTIFICATION.—An application for certifi-
24 cation under this part meets the requirements of this sec-
25 tion only if it includes, in a manner and form which shall



1 be prescribed by the applicable authority through nego-
2 tiated rulemaking, at least the following information:

3 “(1) IDENTIFYING INFORMATION.—The names
4 and addresses of—

5 “(A) the sponsor; and

6 “(B) the members of the board of trustees
7 of the plan.

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

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

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

24 “(5) AGREEMENTS WITH SERVICE PRO-
25 VIDERS.—A copy of any agreements between the



1 plan and contract administrators and other service
2 providers.

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

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

18 “(B) ADEQUACY OF CONTRIBUTION
19 RATES.—A statement of actuarial opinion,
20 signed by a qualified actuary, which sets forth
21 a description of the extent to which contribution
22 rates are adequate to provide for the payment
23 of all obligations and the maintenance of re-
24 quired reserves under the plan for the 12-
25 month period beginning with such date within



1 such 120-day period, taking into account the
2 expected coverage and experience of the plan. If
3 the contribution rates are not fully adequate,
4 the statement of actuarial opinion shall indicate
5 the extent to which the rates are inadequate
6 and the changes needed to ensure adequacy.

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

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

23 “(E) OTHER INFORMATION.—Any other
24 information as may be determined by the appli-
25 cable authority, by regulation through nego-



1 tiated rulemaking, as necessary to carry out the
2 purposes of this part.

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

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

24 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
25 SOCIATION HEALTH PLANS.—An association health plan



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

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



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

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

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

8 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
9 **MINATION.**

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

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

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

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



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

4 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
5 **NATION.**

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



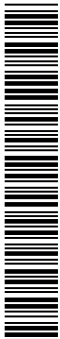
1 prescribe by regulation through negotiated rulemaking) of
2 such recommendations of the actuary for corrective action,
3 together with a description of the actions (if any) that the
4 board has taken or plans to take in response to such rec-
5 ommendations. The board shall thereafter report to the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

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

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

20 “(2) the applicable authority determines that
21 there is a reasonable expectation that the plan will
22 continue to fail to meet the requirements of section
23 806,

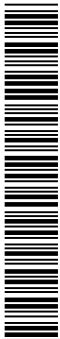
24 the board of trustees of the plan shall, at the direction
25 of the applicable authority, terminate the plan and, in the



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

9 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
10 **VENT ASSOCIATION HEALTH PLANS PRO-**
11 **VIDING HEALTH BENEFITS IN ADDITION TO**
12 **HEALTH INSURANCE COVERAGE.**

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



1 court shall appoint such Secretary trustee if the court de-
2 termines that the trusteeship is necessary to protect the
3 interests of the participants and beneficiaries or providers
4 of medical care or to avoid any unreasonable deterioration
5 of the financial condition of the plan. The trusteeship of
6 such Secretary shall continue until the conditions de-
7 scribed in the first sentence of this subsection are rem-
8 edied or the plan is terminated.

9 “(b) POWERS AS TRUSTEE.—The Secretary, upon
10 appointment as trustee under subsection (a), shall have
11 the power—

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

15 “(2) to require the transfer of all (or any part)
16 of the assets and records of the plan to the Sec-
17 retary as trustee;

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

23 “(4) to require the sponsor, the plan adminis-
24 trator, any participating employer, and any employee
25 organization representing plan participants to fur-



1 nish any information with respect to the plan which
2 the Secretary as trustee may reasonably need in
3 order to administer the plan;

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

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

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

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

19 “(9) to provide for the enrollment of plan par-
20 ticipants and beneficiaries under appropriate cov-
21 erage options; and

22 “(10) to do such other acts as may be nec-
23 essary to comply with this title or any order of the
24 court and to protect the interests of plan partici-



1 pants and beneficiaries and providers of medical
2 care.

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

6 “(1) the sponsor and plan administrator;

7 “(2) each participant;

8 “(3) each participating employer; and

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

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

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



1 “(f) JURISDICTION OF COURT.—

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



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

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

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

15 “(a) IN GENERAL.—Notwithstanding section 514, a
16 State may impose by law a contribution tax on an associa-
17 tion health plan described in section 806(a)(2), if the plan
18 commenced operations in such State after the date of the
19 enactment of the Bipartisan Patient Protection Act.

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

24 “(1) such tax is computed by applying a rate to
25 the amount of premiums or contributions, with re-

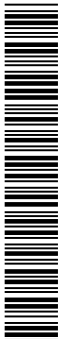


1 spect to individuals covered under the plan who are
2 residents of such State, which are received by the
3 plan from participating employers located in such
4 State or from such individuals;

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

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

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



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

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

3 “(1) GROUP HEALTH PLAN.—The term ‘group
4 health plan’ has the meaning provided in section
5 733(a)(1) (after applying subsection (b) of this sec-
6 tion).

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

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

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

15 “(5) APPLICABLE AUTHORITY.—

16 “(A) IN GENERAL.—Except as provided in
17 subparagraph (B), the term ‘applicable author-
18 ity’ means, in connection with an association
19 health plan—

20 “(i) the State recognized pursuant to
21 subsection (c) of section 506 as the State
22 to which authority has been delegated in
23 connection with such plan; or

24 “(ii) if there if no State referred to in
25 clause (i), the Secretary.

26 “(B) EXCEPTIONS.—



1 “(i) JOINT AUTHORITIES.—Where
2 such term appears in section 808(3), sec-
3 tion 807(e) (in the first instance), section
4 809(a) (in the second instance), section
5 809(a) (in the fourth instance), and sec-
6 tion 809(b)(1), such term means, in con-
7 nection with an association health plan, the
8 Secretary and the State referred to in sub-
9 paragraph (A)(i) (if any) in connection
10 with such plan.

11 “(ii) REGULATORY AUTHORITIES.—
12 Where such term appears in section 802(a)
13 (in the first instance), section 802(d), sec-
14 tion 802(e), section 803(d), section
15 805(a)(5), section 806(a)(2), section
16 806(b), section 806(c), section 806(d),
17 paragraphs (1)(A) and (2)(A) of section
18 806(g), section 806(h), section 806(i), sec-
19 tion 806(j), section 807(a) (in the second
20 instance), section 807(b), section 807(d),
21 section 807(e) (in the second instance),
22 section 808 (in the matter after paragraph
23 (3)), and section 809(a) (in the third in-
24 stance), such term means, in connection



1 with an association health plan, the Sec-
2 retary.

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

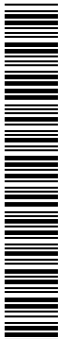
6 “(7) INDIVIDUAL MARKET.—

7 “(A) IN GENERAL.—The term ‘individual
8 market’ means the market for health insurance
9 coverage offered to individuals other than in
10 connection with a group health plan.

11 “(B) TREATMENT OF VERY SMALL
12 GROUPS.—

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

20 “(ii) STATE EXCEPTION.—Clause (i)
21 shall not apply in the case of health insur-
22 ance coverage offered in a State if such
23 State regulates the coverage described in
24 such clause in the same manner and to the
25 same extent as coverage in the small group



1 market (as defined in section 2791(e)(5) of
2 the Public Health Service Act) is regulated
3 by such State.

4 “(8) PARTICIPATING EMPLOYER.—The term
5 ‘participating employer’ means, in connection with
6 an association health plan, any employer, if any indi-
7 vidual who is an employee of such employer, a part-
8 ner in such employer, or a self-employed individual
9 who is such employer (or any dependent, as defined
10 under the terms of the plan, of such individual) is
11 or was covered under such plan in connection with
12 the status of such individual as such an employee,
13 partner, or self-employed individual in relation to the
14 plan.

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

22 “(10) QUALIFIED ACTUARY.—The term ‘quali-
23 fied actuary’ means an individual who is a member
24 of the American Academy of Actuaries or meets
25 such reasonable standards and qualifications as the



1 Secretary may provide by regulation through nego-
2 tiated rulemaking.

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

5 “(A) a person who is otherwise eligible to
6 be a member of the sponsor but who elects an
7 affiliated status with the sponsor,

8 “(B) in the case of a sponsor with mem-
9 bers which consist of associations, a person who
10 is a member of any such association and elects
11 an affiliated status with the sponsor, or

12 “(C) in the case of an association health
13 plan in existence on the date of the enactment
14 of the Bipartisan Patient Protection Act, a per-
15 son eligible to be a member of the sponsor or
16 one of its member associations.

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

24 “(13) SMALL EMPLOYER.—The term ‘small em-
25 ployer’ means, in connection with a group health



1 plan with respect to a plan year, an employer who
2 is not a large employer.

3 “(b) RULES OF CONSTRUCTION.—

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

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

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

21 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
22 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
23 case of any plan, fund, or program which was estab-
24 lished or is maintained for the purpose of providing
25 medical care (through the purchase of insurance or



1 otherwise) for employees (or their dependents) cov-
2 ered thereunder and which demonstrates to the Sec-
3 retary that all requirements for certification under
4 this part would be met with respect to such plan,
5 fund, or program if such plan, fund, or program
6 were a group health plan, such plan, fund, or pro-
7 gram shall be treated for purposes of this title as an
8 employee welfare benefit plan on and after the date
9 of such demonstration.”.

10 (b) CONFORMING AMENDMENTS TO PREEMPTION
11 RULES.—

12 (1) Section 514(b)(6) of such Act (29 U.S.C.
13 1144(b)(6)) is amended by adding at the end the
14 following new subparagraph:

15 “(E) The preceding subparagraphs of this paragraph
16 do not apply with respect to any State law in the case
17 of an association health plan which is certified under part
18 8.”.

19 (2) Section 514 of such Act (29 U.S.C. 1144),
20 as amended by section 142, is amended—

21 (A) in subsection (b)(4), by striking “Sub-
22 section (a)” and inserting “Subsections (a) and
23 (e)”;

24 (B) in subsection (b)(5), by striking “sub-
25 section (a)” in subparagraph (A) and inserting



1 “subsection (a) of this section and subsections
2 (a)(2)(B) and (b) of section 805”, and by strik-
3 ing “subsection (a)” in subparagraph (B) and
4 inserting “subsection (a) of this section or sub-
5 section (a)(2)(B) or (b) of section 805”;

6 (C) by redesignating subsection (e) as sub-
7 section (f); and

8 (D) by inserting after subsection (d) the
9 following new subsection:

10 “(e)(1) Except as provided in subsection (b)(4), the
11 provisions of this title shall supersede any and all State
12 laws insofar as they may now or hereafter preclude, or
13 have the effect of precluding, a health insurance issuer
14 from offering health insurance coverage in connection with
15 an association health plan which is certified under part
16 8.

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

19 “(A) In any case in which health insurance cov-
20 erage of any policy type is offered under an associa-
21 tion health plan certified under part 8 to a partici-
22 pating employer operating in such State, the provi-
23 sions of this title shall supersede any and all laws
24 of such State insofar as they may preclude a health
25 insurance issuer from offering health insurance cov-

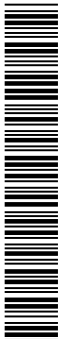


1 erage of the same policy type to other employers op-
2 erating in the State which are eligible for coverage
3 under such association health plan, whether or not
4 such other employers are participating employers in
5 such plan.

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

18 “(3) For additional provisions relating to association
19 health plans, see subsections (a)(2)(B) and (b) of section
20 805.

21 “(4) For purposes of this subsection, the term ‘asso-
22 ciation health plan’ has the meaning provided in section
23 801(a), and the terms ‘health insurance coverage’, ‘par-
24 ticipating employer’, and ‘health insurance issuer’ have



1 the meanings provided such terms in section 811, respec-
2 tively.”.

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

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

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

12 (C) by adding at the end the following new
13 clause:

14 “(iii) subject to subparagraph (E), in the case
15 of any other employee welfare benefit plan which is
16 a multiple employer welfare arrangement and which
17 provides medical care (within the meaning of section
18 733(a)(2)), any law of any State which regulates in-
19 surance may apply.”.

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

22 (A) by striking “Nothing” and inserting
23 “(1) Except as provided in paragraph (2), noth-
24 ing”; and



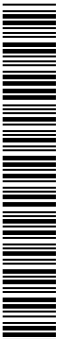
1 (B) by adding at the end the following new
2 paragraph:

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of the Bipartisan
5 Patient Protection Act shall be construed to alter, amend,
6 modify, invalidate, impair, or supersede any provision of
7 this title, except by specific cross-reference to the affected
8 section.”.

9 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
10 (29 U.S.C. 102(16)(B)) is amended by adding at the end
11 the following new sentence: “Such term also includes a
12 person serving as the sponsor of an association health plan
13 under part 8.”.

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

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



1 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
2 CATION OF SELF-INSURED ASSOCIATION HEALTH
3 PLANS.—Not later than January 1, 2006, the Secretary
4 of Labor shall report to the Committee on Education and
5 the Workforce of the House of Representatives and the
6 Committee on Health, Education, Labor, and Pensions of
7 the Senate the effect association health plans have had,
8 if any, on reducing the number of uninsured individuals.

9 (g) CLERICAL AMENDMENT.—The table of contents
10 in section 1 of the Employee Retirement Income Security
11 Act of 1974 is amended by inserting after the item relat-
12 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. Definitions and rules of construction.”.

13 **SEC. 422. CLARIFICATION OF TREATMENT OF SINGLE EM-**
14 **PLOYER ARRANGEMENTS.**

15 Section 3(40)(B) of the Employee Retirement Income
16 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is
17 amended—



1 (1) in clause (i), by inserting “for any plan year
2 of any such plan, or any fiscal year of any such
3 other arrangement;” after “single employer”, and by
4 inserting “during such year or at any time during
5 the preceding 1-year period” after “control group”;

6 (2) in clause (iii)—

7 (A) by striking “common control shall not
8 be based on an interest of less than 25 percent”
9 and inserting “an interest of greater than 25
10 percent may not be required as the minimum
11 interest necessary for common control”; and

12 (B) by striking “similar to” and inserting
13 “consistent and coextensive with”;

14 (3) by redesignating clauses (iv) and (v) as
15 clauses (v) and (vi), respectively; and

16 (4) by inserting after clause (iii) the following
17 new clause:

18 “(iv) in determining, after the application of
19 clause (i), whether benefits are provided to employ-
20 ees of two or more employers, the arrangement shall
21 be treated as having only one participating employer
22 if, after the application of clause (i), the number of
23 individuals who are employees and former employees
24 of any one participating employer and who are cov-
25 ered under the arrangement is greater than 75 per-



1 cent of the aggregate number of all individuals who
2 are employees or former employees of participating
3 employers and who are covered under the arrange-
4 ment;”.

5 **SEC. 423. CLARIFICATION OF TREATMENT OF CERTAIN**
6 **COLLECTIVELY BARGAINED ARRANGE-**
7 **MENTS.**

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

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

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

24 “(C) For purposes of subparagraph (A)(i)(II), a plan
25 or other arrangement shall be treated as established or



1 maintained in accordance with this subparagraph only if
2 the following requirements are met:

3 “(i) The plan or other arrangement, and the
4 employee organization or any other entity sponsoring
5 the plan or other arrangement, do not—

6 “(I) utilize the services of any licensed in-
7 surance agent or broker for soliciting or enroll-
8 ing employers or individuals as participating
9 employers or covered individuals under the plan
10 or other arrangement; or

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

24 except to the extent that the services used by the
25 plan, arrangement, organization, or other entity con-



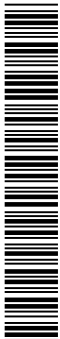
1 sist solely of preparation of documents necessary for
2 compliance with the reporting and disclosure re-
3 quirements of part 1 or administrative, investment,
4 or consulting services unrelated to solicitation or en-
5 rollment of covered individuals.

6 “(ii) As of the end of the preceding plan year,
7 the number of covered individuals under the plan or
8 other arrangement who are neither—

9 “(I) employed within a bargaining unit
10 covered by any of the collective bargaining
11 agreements with a participating employer (nor
12 covered on the basis of an individual’s employ-
13 ment in such a bargaining unit); nor

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

22 does not exceed 15 percent of the total number of
23 individuals who are covered under the plan or ar-
24 rangement and who are present or former employees
25 who are or were covered under the plan or arrange-



1 ment pursuant to a collective bargaining agreement
2 with a participating employer. The requirements of
3 the preceding provisions of this clause shall be treat-
4 ed as satisfied if, as of the end of the preceding plan
5 year, such covered individuals are comprised solely
6 of individuals who were covered individuals under
7 the plan or other arrangement as of the date of the
8 enactment of the Bipartisan Patient Protection Act
9 and, as of the end of the preceding plan year, the
10 number of such covered individuals does not exceed
11 25 percent of the total number of present and
12 former employees enrolled under the plan or other
13 arrangement.

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

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



1 “(i) all of the benefits provided under the plan
2 or arrangement consist of health insurance coverage;
3 or

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

6 “(II) the requirements of clause (B) of the pro-
7 viso to clause (5) of section 302(c) of the Labor
8 Management Relations Act, 1947 (29 U.S.C.
9 186(c)) are met with respect to such plan or other
10 arrangement.

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

14 “(i) the plan or arrangement is in effect as of
15 the date of the enactment of the Bipartisan Patient
16 Protection Act; or

17 “(ii) the employee organization or other entity
18 sponsoring the plan or arrangement—

19 “(I) has been in existence for at least 3
20 years; or

21 “(II) demonstrates to the satisfaction of
22 the Secretary that the requirements of subpara-
23 graphs (C) and (D) are met with respect to the
24 plan or other arrangement.”.



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

7 **SEC. 424. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
8 **CIATION HEALTH PLANS.**

9 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
10 MISREPRESENTATIONS.—Section 501 of the Employee
11 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
12 is amended—

13 (1) by inserting “(a)” after “SEC. 501.”; and

14 (2) by adding at the end the following new sub-
15 section:

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

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

24 “(2) having been established or maintained
25 under or pursuant to one or more collective bar-



1 gaining agreements which are reached pursuant to
2 collective bargaining described in section 8(d) of the
3 National Labor Relations Act (29 U.S.C. 158(d)) or
4 paragraph Fourth of section 2 of the Railway Labor
5 Act (45 U.S.C. 152, paragraph Fourth) or which are
6 reached pursuant to labor-management negotiations
7 under similar provisions of State public employee re-
8 lations laws; or

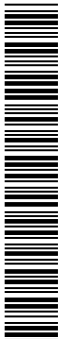
9 “(3) being a plan or arrangement with respect
10 to which the requirements of subparagraph (C), (D),
11 or (E) of section 3(40) are met;

12 shall, upon conviction, be imprisoned not more than 5
13 years, be fined under title 18, United States Code, or
14 both.”.

15 (b) CEASE ACTIVITIES ORDERS.—Section 502 of
16 such Act (29 U.S.C. 1132), as amended by sections 141
17 and 143, is further amended by adding at the end the
18 following new subsection:

19 “(p) ASSOCIATION HEALTH PLAN CEASE AND DE-
20 SIST ORDERS.—

21 “(1) IN GENERAL.—Subject to paragraph (2),
22 upon application by the Secretary showing the oper-
23 ation, promotion, or marketing of an association
24 health plan (or similar arrangement providing bene-



1 fits consisting of medical care (as defined in section
2 733(a)(2))) that—

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

9 “(B) is an association health plan certified
10 under part 8 and is not operating in accordance
11 with the requirements under part 8 for such
12 certification,

13 a district court of the United States shall enter an
14 order requiring that the plan or arrangement cease
15 activities.

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

20 “(A) all benefits under it referred to in
21 paragraph (1) consist of health insurance cov-
22 erage; and

23 “(B) with respect to each State in which
24 the plan or arrangement offers or provides ben-
25 efits, the plan or arrangement is operating in



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

13 “(c) ASSOCIATION HEALTH PLANS.—The terms of
14 each association health plan which is or has been certified
15 under part 8 shall require the board of trustees or the
16 named fiduciary (as applicable) to ensure that the require-
17 ments of this section are met in connection with claims
18 filed under the plan.”.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:



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

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

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

12 “(2) RECOGNITION OF PRIMARY DOMICILE
13 STATE.—In carrying out paragraph (1), the Sec-
14 retary shall ensure that only one State will be recog-
15 nized, with respect to any particular association
16 health plan, as the State to with which consultation
17 is required. In carrying out this paragraph, the Sec-
18 retary shall take into account the places of residence
19 of the participants and beneficiaries under the plan
20 and the State in which the trust is maintained.”.

21 **SEC. 426. EFFECTIVE DATE AND TRANSITIONAL AND**
22 **OTHER RULES.**

23 (a) EFFECTIVE DATE.—The amendments made by
24 sections 421, 424, and 425 shall take effect one year from
25 the date of enactment. The amendments made by sections

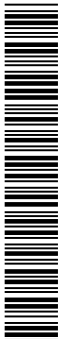


1 422 and 423 shall take effect on the date of the enactment
2 of this Act. The Secretary of Labor shall first issue all
3 regulations necessary to carry out the amendments made
4 by this subtitle within one year from the date of enact-
5 ment. Such regulations shall be issued through negotiated
6 rulemaking.

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

15 (c) TREATMENT OF CERTAIN EXISTING HEALTH
16 BENEFITS PROGRAMS.—

17 (1) IN GENERAL.—In any case in which, as of
18 the date of the enactment of this Act, an arrange-
19 ment is maintained in a State for the purpose of
20 providing benefits consisting of medical care for the
21 employees and beneficiaries of its participating em-
22 ployers, at least 200 participating employers make
23 contributions to such arrangement, such arrange-
24 ment has been in existence for at least 10 years, and
25 such arrangement is licensed under the laws of one



1 or more States to provide such benefits to its par-
2 ticipating employers, upon the filing with the appli-
3 cable authority (as defined in section 812(a)(5) of
4 the Employee Retirement Income Security Act of
5 1974 (as amended by this subtitle)) by the arrange-
6 ment of an application for certification of the ar-
7 rangement under part 8 of subtitle B of title I of
8 such Act—

9 (A) such arrangement shall be deemed to
10 be a group health plan for purposes of title I
11 of such Act;

12 (B) the requirements of sections 801(a)(1)
13 and 803(a)(1) of the Employee Retirement In-
14 come Security Act of 1974 shall be deemed met
15 with respect to such arrangement;

16 (C) the requirements of section 803(b) of
17 such Act shall be deemed met, if the arrange-
18 ment is operated by a board of directors
19 which—

20 (i) is elected by the participating em-
21 ployers, with each employer having one
22 vote; and

23 (ii) has complete fiscal control over
24 the arrangement and which is responsible
25 for all operations of the arrangement;



1 (D) the requirements of section 804(a) of
2 such Act shall be deemed met with respect to
3 such arrangement; and

4 (E) the arrangement may be certified by
5 any applicable authority with respect to its op-
6 erations in any State only if it operates in such
7 State on the date of certification.

8 The provisions of this subsection shall cease to apply
9 with respect to any such arrangement at such time
10 after the date of the enactment of this Act as the
11 applicable requirements of this subsection are not
12 met with respect to such arrangement.

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

Amend section 511 to read as follows (and conform
the table of contents accordingly):



SEC. 511. EXPANSION OF AVAILABILITY OF ARCHER MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(1) of such Code (relating to eligible individual) is amended to read as follows:

“(A) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, any individual if—

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



“(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

“(I) which is not a high deductible health plan, and

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

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:



“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to $\frac{1}{12}$ of the annual deductible (as of the first day of such month) of the individual’s coverage under the high deductible health plan.”.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking “75 percent of”.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

“(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer’s gross income for such taxable year.”.

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—



(A) by striking “\$1,500” in clause (i) and inserting “\$1,000”; and

(B) by striking “\$3,000” in clause (ii) and inserting “\$2,000”.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

“(g) COST-OF-LIVING ADJUSTMENT.—

“(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 1997’ for ‘calendar year 1992’ in subparagraph (B) thereof.

“(2) SPECIAL RULES.—In the case of the \$1,000 amount in subsection (c)(2)(A)(i) and the \$2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting ‘calendar year 2000’ for ‘calendar year 1997’.

1 “(3) ROUNDING.—If any increase under para-
2 graph (1) or (2) is not a multiple of \$50, such in-



1 crease shall be rounded to the nearest multiple of
2 \$50.”.

3 (f) PROVIDING INCENTIVES FOR PREFERRED PRO-
4 VIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS AC-
5 COUNTS.—

6 (1) PREVENTIVE CARE COVERAGE PER-
7 MITTED.—Clause (ii) of section 220(c)(2)(B) of such
8 Code is amended by striking “preventive care if”
9 and all that follows and inserting “preventive care.”

10 (2) TREATMENT OF NETWORK SERVICES.—
11 Subparagraph (B) of section 220(c)(2) of such Code
12 is amended by adding at the end the following new
13 clause:

14 “(iii) TREATMENT OF NETWORK
15 SERVICES.—In the case of a health plan
16 which provides benefits for services pro-
17 vided by providers in a network (as defined
18 in section 161 of the Patient’s Bill of
19 Rights Act of 2001) and which would
20 (without regard to services provided by
21 providers outside the network) be a high
22 deductible health plan, such plan shall not
23 fail to be a high deductible health plan
24 because—



1 “(I) the annual deductible for
2 services provided by providers outside
3 the network exceeds the applicable
4 maximum dollar amount in clause (i)
5 or (ii), or

6 “(II) the annual out-of-pocket ex-
7 penses required to be paid for services
8 provided by providers outside the net-
9 work exceeds the applicable dollar
10 amount in clause (iii).

11 The annual deductible taken into account
12 under subsection (b)(2) with respect to a
13 plan to which the preceding sentence ap-
14 plies shall be the annual deductible for
15 services provided by providers within the
16 network.”

17 (g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED
18 UNDER CAFETERIA PLANS.—Subsection (f) of section
19 125 of such Code is amended by striking “106(b),”.

20 (h) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 2001.

