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113TH CONGRESS
1ST SESSION

H. R. 2688

To improve healthcare-related, tax-preferred savings accounts and to provide for cooperative governing of individual and group health insurance coverage across State lines, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 15, 2013

Mr. ROSS introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, 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 improve healthcare-related, tax-preferred savings accounts and to provide for cooperative governing of individual and group health insurance coverage across State lines, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Providing Accountability and Transparency to Incentivize Economically Necessary Transitions in Health

Care Act of 2013'' or the ''PATIENT's Health Care Act of 2013''.

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

TITLE I—HEALTHCARE-RELATED SAVINGS ACCOUNTS

SEC. 101. DEDUCTION OF PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

"(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction for the taxable year the aggregate amount paid by such individual as premiums under a high deductible health plan with respect to months during such year for which such individual is an eligible individual with respect to such health plan.

"(b) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—

"(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.

"(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

"(i) coverage for any benefit provided by permitted insurance,

"(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, and

"(iii) coverage under a health flexible spending arrangement during any period immediately following the end of a plan year of such arrangement during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during such period if—

"(I) the balance in such arrangement at the end of such plan year is zero, or

"(II) the individual is making a qualified HSA distribution (as defined in section 106(e)) in an amount equal to the remaining balance in such ar-

rangement as of the end of such plan year, in accordance with rules prescribed by the Secretary.

"(2) HIGH DEDUCTIBLE HEALTH PLAN.—

"(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—

"(i) which has an annual deductible which is not less than—

"(I) $1,000 for self-only coverage, and

"(II) twice the dollar amount in subclause (I) for family coverage, and

"(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

"(I) $5,000 for self-only coverage, and

"(II) twice the dollar amount in subclause (I) for family coverage.

"(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is described in paragraph (1)(B).

''(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).

''(D) SPECIAL RULE FOR ANNUAL OUT-OF-POCKET LIMITATION FOR NETWORK PLANS.—In the case of a plan using a network of providers, such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

''(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

''(A) insurance if substantially all of the coverage provided under such insurance relates to—

''(i) liabilities incurred under workers' compensation laws,

''(ii) tort liabilities,

''(iii) liabilities relating to ownership or use of property, or

''(iv) such other similar liabilities as the Secretary may specify by regulations,

''(B) insurance for a specified disease or illness, and

''(C) insurance paying a fixed amount per day (or other period) of hospitalization.

''(4) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

''(c) SPECIAL RULES.—

''(1) DEDUCTION ALLOWABLE FOR ONLY 1 PLAN.—For purposes of this section, in the case of an individual covered by more than 1 high deductible health plan for any month, the individual may only take into account amounts paid for 1 of such plans for such month.

''(2) EMPLOYER PROVIDED COVERAGE.—

''(A) IN GENERAL.—No deduction shall be allowed to an individual under subsection (a) for any amount paid for coverage under a high deductible health plan for a month if that individual participates in any coverage for such month that is excluded (in whole or in part) from the gross income of the individual or the individual's spouse under section 106.

''(B) CAFETERIA PLANS, ETC.—Employer contributions to a cafeteria plan or a flexible spending or similar arrangement which are excluded from gross income under section 106 shall be treated for purposes of this section as paid by the employer.

''(3) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNT REQUIRED.—A deduction shall not be allowed under subsection (a) for a taxable year with respect to such individual if such individual is not allowed a deduction under section 223 for such taxable year.

''(4) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Subsection (a) shall not apply with respect to any amount which is paid or distributed out of an Archer MSA or a health savings account which is not included in gross income under section 220(f) or 223(f), as the case may be.

''(5) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE OF SELF-EMPLOYED INDIVIDUALS.—The amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (21) the following new paragraph:

''(22) PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.—The deduction allowed by section 224.''.

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 224. Premiums for high deductible health plans.
''Sec. 225. Cross reference.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 102. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN REQUIREMENT.

(a) IN GENERAL.—Subsection (a) of section 223 of such Code is amended to read as follows:

''(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction for a taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 223 of such Code is amended by striking subsection (c) and redesignating subsections (d) through (h) as subsections (c) through (g), respectively.

(2) Section 223(b) of such Code is amended by striking paragraph (8).

(3) Subparagraph (A) of section 223(c)(1) of such Code (as redesignated by paragraph (1)) is amended—

(A) by striking ''subsection (f)(5)'' and inserting ''subsection (e)(5)'', and

(B) in clause (ii)—

(i) by striking ''the sum of—'' and all that follows and inserting ''the dollar amount in effect under subsection (b)(1).''.

(4) Section 223(f)(1) of such Code (as redesignated by paragraph (1)) is amended by striking ''Each dollar amount in subsections (b)(2) and (c)(2)(A)'' and inserting ''In the case of a taxable

year beginning after December 31, 2010, each dollar amount in subsection (b)(1)''.

(5) Section 26(b)(U) of such Code is amended by striking ''section 223(f)(4)'' and inserting ''section 223(e)(4)''.

(6) Sections 35(g)(3), 220(f)(5)(A), 848(e)(1)(v), 4973(a)(5), and 6051(a)(12) of such Code are each amended by striking ''section 223(d)'' each place it appears and inserting ''section 223(e)''.

(7) Section 106(d)(1) of such Code is amended—

(A) by striking ''who is an eligible individual (as defined in section 223(e)(1))'', and

(B) by striking ''section 223(d)'' and inserting ''section 223(e)''.

(8) Section 408(d)(9) of such Code is amended—

(A) in subparagraph (A) by striking ''who is an eligible individual (as defined in section 223(e)) and'', and

(B) in subparagraph (C) by striking ''computed on the basis of the type of coverage under the high deductible health plan covering the individual at the time of the qualified HSA funding distribution''.

(9) Section 877A(g)(6) of such Code is amended by striking ''223(f)(4)'' and inserting ''223(e)(4)''.

(10) Section 4973(g) of such Code is amended—

(A) by striking ''section 223(d)'' and inserting ''section 223(c)'',

(B) in paragraph (2), by striking ''section 223(f)(2)'' and inserting ''section 223(e)(2)'', and

(C) by striking ''section 223(f)(3)'' and inserting ''section 223(e)(3)''.

(11) Section 4975 of such Code is amended—

(A) in subsection (c)(6)—

(i) by striking ''section 223(d)'' and inserting ''section 223(c)'', and

(ii) by striking ''section 223(e)(2)'' and inserting ''section 223(d)(2)'', and

(B) in subsection (e)(1)(E), by striking ''section 223(d)'' and inserting ''section 223(c)''.

(12) Section 6693(a)(2)(C) of such Code is amended by striking ''section 223(h)'' and inserting ''section 223(g)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2011.

SEC. 103. INCREASE IN DEDUCTIBLE HSA CONTRIBUTION LIMITATIONS.

(a) IN GENERAL.—Paragraph (1) of section 223(b) of the Internal Revenue Code of 1986 is amended by striking ''the sum of the monthly'' and all that follows through ''eligible individual'' and inserting ''$10,000 ($20,000 in the case of a joint return)''.

(b) ADDITIONAL CONTRIBUTIONS.—Paragraph (3) of section 223(b) is amended to read as follows:

''(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS BETWEEN 55 AND 65.—In the case of an individual who has attained the age of 55, but has not attained the age of 66, before the close of the taxable year, the limitation under paragraph (1) shall be increased by $10,000.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 223(b) of such Code, as amended by this Act, is amended by striking paragraphs (2) and (5) and by redesignating paragraphs (3), (4), (6), and (7) as paragraphs (2), (3), (4), and (5), respectively.

(2) Section 223(c)(1)(A)(ii) of such Code (as redesignated by this Act) is amended by striking ''the sum of—'' and all that follows and inserting ''the dollar amount in effect under subsection (b)(1).''.

(3) Section 223(f)(1) of such Code (as redesignated by this Act) is amended by striking ''Each dollar amount in subsections (b)(2) and (c)(2)(A)'' and inserting ''In the case of a taxable year beginning after December 31, 2013, each dollar amount in subsection (b)(1)''.

(4) Paragraph (3) of section 223(b) of such Code (as redesignated by paragraph (1)) is amended by striking the last sentence.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 104. MEDICARE ELIGIBLE INDIVIDUALS ELIGIBLE TO CONTRIBUTE TO HSA.

(a) Subsection (b) of section 223 of the Internal Revenue Code of 1986, as amended by this Act, is amended by striking paragraph (4).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 105. HSA ROLLOVER TO MEDICARE ADVANTAGE MSA.

(a) IN GENERAL.—Paragraph (2) of section 138(b) of the Internal Revenue Code of 1986 is amended by striking ''or'' at the end of subparagraph (A), by adding ''or'' at the end of subparagraph (C), and by adding at the end the following new subparagraph:

''(C) a HSA rollover contribution described in subsection (c)(5),''.

(b) HSA ROLLOVER CONTRIBUTION.—Subsection (c) of section 138 of such Code is amended by adding at the end the following new paragraph:

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—The requirements of this subparagraph are met in the case of an amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a Medicare Advantage MSA of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subpara-

graph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of section 223(e)(5)(A).''.

(c) CONFORMING AMENDMENT.—Subparagraph (A) of section 223(e)(5) of such Code, as amended by this Act, is amended by inserting ''or Medicare Advantage MSA'' after ''into a health savings account''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 106. ONE-TIME TRANSFER OF FLEXIBLE SPENDING ARRANGEMENT BALANCE TO HEALTH SAVINGS ACCOUNT IN CASE OF SEPARATION FROM EMPLOYMENT.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by redesignating subsection (j) as subsection (k) and by inserting after subsection (i) the following new subsection:

''(j) ONE-TIME TRANSFER OF REMAINING BALANCE IN HEALTH FLEXIBLE SPENDING ARRANGEMENT AFTER SEPARATION FROM EMPLOYMENT.—

''(1) IN GENERAL.—For purposes of this title, a plan shall not fail to be treated as a health flexible spending arrangement solely because a participant may, in connection with separation from employment with the employer, direct amounts in the participant's account under such arrangement to be contributed on behalf of the participant to a health savings account (as defined in section 223(c)) maintained for the benefit of the participant.''.

(b) CONFORMING AMENDMENT.—Section 223(c)(1)(A) of such Code, as amended by this Act, is amended by striking ''or section 220(f)(5)'' and inserting '', section 125(j), or section 220(f)(5)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 107. PAYMENT OF HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS FROM HSA.

(a) IN GENERAL.—Subparagraph (B) of section 223(c)(2) of such Code, as amended by this Act, is amended by inserting ''other than a high deductible plan (as defined in section 224(b)(2))'' before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 108. REPEAL OF DISQUALIFICATION OF EXPENSES FOR OVER-THE-COUNTER DRUGS UNDER CERTAIN ACCOUNTS AND ARRANGEMENTS.

(a) HSAS.—Subparagraph (A) of section 223(c)(2) of the Internal Revenue Code of 1986, as amended by this Act, is amended by striking the last sentence.

(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of such Code is amended by striking the last sentence.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by striking subsection (f).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred after December 31, 2013.

SEC. 109. PAYMENT OF LONG-TERM CARE PREMIUMS FROM HEALTH FLEXIBLE SPENDING ARRANGEMENT.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986, as amended by this Act, is amended

by inserting after subsection (h) the following new subsection:

''(i) PAYMENT OF LONG-TERM CARE PREMIUMS FROM HEALTH FLEXIBLE SPENDING ARRANGEMENT.—

''(1) IN GENERAL.—No payment for insurance may be made from a health flexible spending arrangement.

''(2) LONG-TERM CARE INSURANCE.—Paragraph (1) shall not apply to any expense for coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 110. ALLOWING MSA AND HSA ROLLOVER TO ADULT CHILD OF ACCOUNT HOLDER.

(a) MSAs.—

(1) IN GENERAL.—Subparagraph (A) of section 220(f)(8) of the Internal Revenue Code of 1986 (relating to treatment after death of account holder) is amended—

(A) by inserting ''or adult child'' after ''surviving spouse'',

(B) by inserting ''or adult child, as the case may be,'' after ''the spouse'', and

(C) by inserting ''or adult child'' after ''spouse'' in the heading thereof.

(2) ADULT CHILD DEFINED.—Paragraph (8) of section 220(f) of such Code is amended by adding at the end the following new subparagraph:

''(C) ADULT CHILD.—For purposes of this paragraph, the term 'adult child' means an individual—

''(i) who is a child of the deceased individual, and

''(ii) with respect to whom a deduction under section 151 would not be allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.''.

(b) HSAS.—

(1) IN GENERAL.—Subparagraph (A) of section 223(e)(8) of such Code, as amended by this Act, is amended—

(A) by inserting ''or adult child'' after ''surviving spouse'',

(B) by inserting ''or adult child, as the case may be,'' after ''the spouse'', and

(C) by inserting ''or adult child'' after ''spouse'' in the heading thereof.

(2) ADULT CHILD DEFINED.—Paragraph (8) of section 223(e) of such Code, as amended by this Act, is amended by adding at the end the following new subparagraph:

"(C) ADULT CHILD.—For purposes of this paragraph, the term 'adult child' has the meaning given such term by section 220(f)(8)(C).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 111. DISPOSITION OF UNUSED HEALTH BENEFITS IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by redesignating subsections (k) and (l) as subsections (l) and (m), respectively, and by inserting after subsection (j) the following:

"(k) CARRYFORWARDS OR PAYMENTS OF CERTAIN UNUSED HEALTH BENEFITS.—

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

"(A) carried forward to the succeeding plan year of such health flexible spending arrangement, or

"(B) paid to or on behalf of an employee as compensation as of the end of such plan year or upon the termination of, or failure to re-enroll in, such plan or arrangement.

"(2) DISTRIBUTION OF UNUSED HEALTH BENEFITS ON BEHALF OF EMPLOYEE.—For purposes of paragraph (1)(B), unused health benefits paid as compensation on behalf of an employee by the employer shall be—

"(A) includible in gross income and wages of the employee, whether or not a deduction for such payment is allowable under this title to the employee, and

"(B) excludable from—

"(i) gross income to the extent provided under section 402(e), 457(a) (with respect to contributions to an eligible deferred compensation plan (as defined in section 457(b)) of an eligible employer described in section 457(e)(1)(A)), or 220, and

''(ii) wages to the extent otherwise provided for amounts so excludable.

''(3) UNUSED HEALTH BENEFITS.—For purposes of this subsection, the term 'unused health benefits' means the excess of—

''(A) the maximum amount of reimbursement allowable during a plan year under a health flexible spending arrangement, over

''(B) the actual amount of reimbursement during such year under such arrangement.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2013.

SEC. 112. PERMITTING BENEFICIARY CONTRIBUTIONS TO MEDICARE ADVANTAGE MSA.

(a) IN GENERAL.—Subsection (b) of section 138 of such Code is amended by striking paragraph (2) and by redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 113. CHILD HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new subsection:

''(h) CHILD HEALTH SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an individual, in addition to any deduction allowed under subsection (a) for any taxable year, there shall be allowed as a deduction under this section an amount equal to the aggregate amount paid in cash by the taxpayer during the taxable year to a child health savings account of a child of the taxpayer.

''(2) LIMITATION.—The amount taken into account under paragraph (1) with respect to each child of the taxpayer for the taxable year shall not exceed an amount equal to $3,000.

''(3) CHILD HEALTH SAVINGS ACCOUNT.—For purposes of this subsection, the term 'child health savings account' means a health savings account designated as a child health savings account and established for the benefit of a child of a taxpayer, but only if—

''(A) such account was established for the benefit of the child before the child attains the age of 5, and

''(B) under the written governing instrument creating the trust, no contribution will be accepted to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the dollar amount in effect under paragraph (2).

''(4) TREATMENT OF ACCOUNT BEFORE AGE 18.—For purposes of this section, except as otherwise provided in this subsection, a child health savings account established for the benefit of the child of a taxpayer shall be treated as a health savings account of the taxpayer until the child attains the age of 18, after which such account shall be treated as a health savings account of the child.

''(5) DISTRIBUTIONS.—

''(A) IN GENERAL.—In the case of a child health savings account established under this section for the benefit of a child of a taxpayer—

''(i) BEFORE AGE 18.—Any amount paid or distributed out of such account before the child has attained the age of 18, shall be included in the gross income of the taxpayer, and subparagraph (A) of subsection (f) shall apply (relating to addi-

tional tax on distributions not used for qualified medical expenses).

''(ii) AGE 18 AND OLDER.—Any amount paid or distributed out of such account after the child has attained the age of 18 may only be treated as used to pay qualified medical expenses to the extent such child is not covered as a dependent under insurance (other than permitted insurance) of a parent.

''(B) EXCEPTIONS FOR DISABILITY OR DEATH OF CHILD.—If the child becomes disabled within the meaning of section 72(m)(7) or dies—

''(i) subparagraph (A) shall not apply to any subsequent payment or distribution, and

''(ii) the taxpayer may rollover the amount in such account to an individual retirement plan of the taxpayer, to any health savings account of the taxpayer, or to any child health savings account of any other child of the taxpayer.

''(C) HEALTH INSURANCE MAY BE PURCHASED FROM ACCOUNT.—Subparagraph (B)

of subsection (d)(2) shall not apply to any health savings account originally established as a child health savings account.

''(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection, including rules for determining application of this subsection in the case of legal guardians and in the case of parents of a child who file separately, are separated, or are not married.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

TITLE II—HEALTH INSURANCE PROVISIONS

SEC. 201. COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.

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

''PART D—COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE

''SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual or group health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual or group health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual or group health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

''(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) GROUP HEALTH INSURANCE COVERAGE.—The term 'group health insurance coverage' has the meaning given such term in 2791(b)(4).

''(6) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

''(7) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

''(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

''(B) to pay other obligations in the normal course of business.

''(8) COVERED LAWS.—

''(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

''(i) individual or group health insurance coverage issued by a health insurance issuer;

''(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual or group health insurance coverage to an individual;

''(iii) the provision to an individual in relation to individual or group health insurance coverage of health care and insurance related services;

''(iv) the provision to an individual in relation to individual or group health insurance coverage of management, oper-

ations, and investment activities of a health insurance issuer; and

''(v) the provision to an individual in relation to individual or group health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

''(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

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

''(10) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

''(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

"(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

"(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

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

"(E) Refusing to pay claims without conducting a reasonable investigation.

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

"(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

"(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary

was entitled by reference to written or printed advertising material accompanying or made part of an application.

''(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

''(J) Failing to provide forms necessary to present claims within 15 calendar days of a request with reasonable explanations regarding their use.

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

''(11) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

''(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

''(ii) The rating of an insurance policy or reinsurance contract.

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

''(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

''SEC. 2796. APPLICATION OF LAW.

''(a) IN GENERAL.—The covered laws of the primary State shall apply to individual and group health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any sec-

ondary State and only if the covered laws of the primary State—

''(1) do not apply any age limitations with respect to who may purchase such coverage that is a high deductible health plan; and

''(2) do not require such coverage that is a high deductible health plan to provide for any specific type of coverage.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual or group health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

''(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

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

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

''(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

''(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

''(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

''(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

"(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

"(ii) in a voluntary dissolution proceeding;

"(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

"(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

"(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

''(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

''(2) require any individual or group health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that secondary State;

''(3) apply any age limitations with respect to who may purchase such coverage that is a high deductible health plan;

''(4) require such coverage that is a high deductible health plan to provide for any specific type of coverage; or

''(5) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5

blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned: 'Notice: This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual or group health insurance coverage to an indi-

vidual under this part in a primary or secondary State may not upon renewal—

"(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health status-related factors of the individual; or

"(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

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

"(B) from raising premium rates for all policyholders within a class based on claims experience;

"(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by

the issuer, if such premium changes or incentives—

"(i) are disclosed to the consumer in the insurance contract;

"(ii) are based on specific wellness activities that are not applicable to all individuals; and

"(iii) are not obtainable by all individuals to whom coverage is offered;

"(D) from reinstating lapsed coverage; or

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

"(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual or group health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

"(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual or group health insurance coverage obtain a license from that State, with commissions or

other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual or group health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual or group health insurance coverage in such State—

''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual or group health insurance coverage, a copy of the issuer's

quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

"(A) a member of the American Academy of Actuaries; or

"(B) a qualified loss reserve specialist.

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

"(1) the solicitation or sale of individual or group health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

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

"(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

''(j) STATE POWERS TO ENFORCE STATE LAWS.—

''(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

''(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for resi-

dents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual or group health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

''(n) NO MANDATED BENEFIT COVERAGE REQUIREMENTS.—Notwithstanding any other provision of law, a health insurance issuer offering individual or group health insurance coverage in a primary State and in any secondary State in accordance with this part (and any coverage so offered) shall not be subject to any Federal law that would otherwise—

''(1) apply any age limitations with respect to who may purchase such coverage that is a high deductible health plan; or

''(2) require such coverage that is a high deductible health plan to provide for any specific type of coverage.

"SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

"A health insurance issuer may not offer, sell, or issue individual or group health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual or group health insurance coverage in a secondary State under the provisions of this title unless—

"(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage or group health insurance offered by a health insurance issuer, respectively, or

"(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such

State) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

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

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

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

''(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

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

''(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

''(I) a non-affiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and

the enrollee (or authorized representative), and neither party objects; or

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

''(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

''(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

''(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty

as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

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

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

''(A) not exceed a reasonable level; and

''(B) not be contingent on the decision rendered by the reviewer.

''(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

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

''(B) The enrollee (or authorized representative).

''(C) The health care professional that provides the items or services involved in the denial.

''(D) The institution at which the items or services (or treatment) involved in the denial are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

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

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an

individual enrolled with the issuer to receive such coverage.

''(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

"SEC. 2799. ENFORCEMENT.

''(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual or group health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

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

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

''(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State, or group health insurance coverage offered

by a health insurance issuer in a secondary State, that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.''.

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

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

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

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

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

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

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

SEC. 202. REAUTHORIZATION OF THE PREEXISTING CONDITION INSURANCE PLAN (PCIP) PROGRAM.

(a) IN GENERAL.—The PCIP program is hereby reauthorized through December 31, 2016, and shall continue in effect subject to the provisions of this section.

(b) ELIMINATION OF REQUIREMENT FOR NONCOVERAGE FOR 6 MONTHS TO BE ELIGIBLE INDIVIDUAL.—The condition under paragraph (2) of section 1101(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18001(d)) shall not apply to the reauthorized PCIP program.

(c) FUNDING.—

(1) INITIAL FUNDING.—Initial funding for the reauthorized PCIP program shall be derived from the following:

(A) Funding that was available in the Patient-Centered Outcomes Research Institute

Trust Fund under section 9511 of the Internal Revenue Code of 1986 on the day before the date of the enactment of this Act.

(B) Any unobligated funds in the Prevention and Public Health Fund (under section 4002 of Public Law 111–148, 42 U.S.C. 300u–11) attributable to fiscal year 2013 as of the day before the date of the enactment of this Act.

(2) SUBSEQUENT FUNDING.—Subsequent funding for the reauthorized PCIP program shall be derived from any funds that would otherwise be made available to such Prevention and Public Health Fund for fiscal years 2014 through 2016.

(3) TRANSFER.—Funding under the previous paragraphs shall be transferred to an account within the Department of Health and Human Services that provided funding, as of the day before the date of the enactment of this Act, to carry out the PCIP program.

(d) DEFINITIONS.—In this section:

(1) The term ''PCIP program'' means the Pre-existing Condition Insurance Plan (PCIP) Program established as of the day before the date of the en-

actment of this Act under section 1101 of Public Law 111–148 (42 U.S.C. 18001).

(2) The term ''reauthorized PCIP program'' means the PCIP program as reauthorized under this section.

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