109TH CONGRESS
1ST SESSION

S. 637

To establish a national health program administered by the Office of Personnel Management to offer health benefits plans to individuals who are not Federal employees, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 16, 2005

Mr. DURBIN (for himself, Mrs. LINCOLN, Mr. CARPER, Mr. PRYOR, Ms. LANDRIEU, Mr. NELSON of Florida, Mr. CORZINE, Mr. LAUTENBERG, Ms. CANTWELL, and Mr. LIEBERMAN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To establish a national health program administered by the Office of Personnel Management to offer health benefits plans to individuals who are not Federal employees, 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.

This Act may be cited as the ''Small Employers Health Benefits Program Act of 2005''.

SEC. 2. DEFINITIONS.

(a) IN GENERAL.—In this Act, the terms ''member of family'', ''health benefits plan'', ''carrier'', ''employee organizations'', and ''dependent'' have the meanings given such terms in section 8901 of title 5, United States Code.

(b) OTHER TERMS.—In this Act:

(1) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)). Such term shall not include an employee of the Federal Government.

(2) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers who employed an average of at least 1 but not more than 100 employees on business days during the year preceding the date of application. Such term shall not include the Federal Government.

(3) HEALTH STATUS-RELATED FACTOR.—The term ''health status-related factor'' has the meaning given such term in section 2791(d)(9) of the Public Health Service Act (42 U.S.C. 300gg–91(d)(9)).

(4) OFFICE.—The term ''Office'' means the Office of Personnel Management.

(5) PARTICIPATING EMPLOYER.—The term ''participating employer'' means an employer that—

(A) elects to provide health insurance coverage under this Act to its employees; and

(B) is not offering other comprehensive health insurance coverage to such employees.

(c) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of subsection (b)(2):

(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence for the full year prior to the date on which the employer applies to participate, the determination of whether such employer meets the requirements of subsection (b)(2) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the employer's first full year.

(3) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(d) WAIVER AND CONTINUATION OF PARTICIPATION.—

(1) WAIVER.—The Office may waive the limitations relating to the size of an employer which may participate in the health insurance program established under this Act on a case by case basis if the Office determines that such employer makes a compelling case for such a waiver. In making determinations under this paragraph, the Office may consider the effects of the employment of temporary and seasonal workers and other factors.

(2) CONTINUATION OF PARTICIPATION.—An employer participating in the program under this Act that experiences an increase in the number of employees so that such employer has in excess of 100 employees, may not be excluded from participation solely as a result of such increase in employees.

SEC. 3. HEALTH INSURANCE COVERAGE FOR NON-FEDERAL EMPLOYEES.

(a) ADMINISTRATION.—The Office shall administer a health insurance program for non-Federal employees and employers in accordance with this Act.

(b) REGULATIONS.—Except as provided under this Act, the Office shall prescribe regulations to apply the provisions of chapter 89 of title 5, United States Code, to the greatest extent practicable to participating carriers, employers, and employees covered under this Act.

(c) LIMITATIONS.—In no event shall the enactment of this Act result in—

(1) any increase in the level of individual or Federal Government contributions required under chapter 89 of title 5, United States Code, including copayments or deductibles;

(2) any decrease in the types of benefits offered under such chapter 89; or

(3) any other change that would adversely affect the coverage afforded under such chapter 89 to employees and annuitants and members of family under that chapter.

(d) ENROLLMENT.—The Office shall develop methods to facilitate enrollment under this Act, including the use of the Internet.

(e) CONTRACTS FOR ADMINISTRATION.—The Office may enter into contracts for the performance of appropriate administrative functions under this Act.

(f) SEPARATE RISK POOL.—In the administration of this Act, the Office shall ensure that covered employees

under this Act are in a risk pool that is separate from the risk pool maintained for covered individuals under chapter 89 of title 5, United States Code.

(g) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to require a carrier that is participating in the program under chapter 89 of title 5, United States Code, to provide health benefits plan coverage under this Act.

SEC. 4. CONTRACT REQUIREMENT.

(a) IN GENERAL.—The Office may enter into contracts with qualified carriers offering health benefits plans of the type described in section 8903 or 8903a of title 5, United States Code, without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to provide health insurance coverage to employees of participating employers under this Act. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Office shall ensure that health benefits coverage is provided for individuals only, married individuals without children, and families.

(b) ELIGIBILITY.—A carrier shall be eligible to enter into a contract under subsection (a) if such carrier—

(1) is licensed to offer health benefits plan coverage in each State in which the plan is offered; and

(2) meets such other requirements as determined appropriate by the Office.

(c) STATEMENT OF BENEFITS.—

(1) IN GENERAL.—Each contract under this Act shall contain a detailed statement of benefits offered and shall include information concerning such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(2) NATIONWIDE PLAN.—The Office shall develop a benefit package that shall be offered in the case of a contract for a health benefit plan that is to be offered on a nationwide basis.

(d) STANDARDS.—The minimum standards prescribed for health benefits plans under section 8902(e) of title 5, United States Code, and for carriers offering plans, shall apply to plans and carriers under this Act. Approval of a plan may be withdrawn by the Office only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

(e) CONVERSION.—

(1) IN GENERAL.—A contract may not be made or a plan approved under this section if the carrier under such contract or plan does not offer to each enrollee whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which the individual may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An enrollee who exercises this option shall pay the full periodic charges of the nongroup contract.

(2) NONCANCELLABLE.—The benefits and coverage made available under paragraph (1) may not be canceled by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(f) RATES.—Rates charged under health benefits plans under this Act shall reasonably and equitably reflect the cost of the benefits provided. Such rates shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefits plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later

contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefits plans to large employers. Rates charged for coverage under this Act shall not vary based on health-status related factors.

(g) REQUIREMENT OF PAYMENT FOR OR PROVISION OF HEALTH SERVICE.—Each contract entered into under this Act shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of title 5, United States Code, is entitled thereto under the terms of the contract.

SEC. 5. ELIGIBILITY.

An individual shall be eligible to enroll in a plan under this Act if such individual—

(1) is an employee of an employer described in section 2(b)(2), or is a self employed individual as defined in section 401(c)(1)(B) of the Internal Revenue Code of 1986; and

(2) is not otherwise enrolled or eligible for enrollment in a plan under chapter 89 of title 5, United States Code.

SEC. 6. ALTERNATIVE CONDITIONS TO FEDERAL EMPLOYEE PLANS.

(a) TREATMENT OF EMPLOYEE.—For purposes of enrollment in a health benefits plan under this Act, an individual who had coverage under a health insurance plan and is not a qualified beneficiary as defined under section 4980B(g)(1) of the Internal Revenue Code of 1986 shall be treated in a similar manner as an individual who begins employment as an employee under chapter 89 of title 5, United States Code.

(b) PREEXISTING CONDITION EXCLUSIONS.—

(1) IN GENERAL.—Each contract under this Act may include a preexisting condition exclusion as defined under section 9801(b)(1) of the Internal Revenue Code of 1986.

(2) EXCLUSION PERIOD.—

(A) IN GENERAL.—A preexisting condition exclusion under this subsection shall provide for coverage of a preexisting condition to begin not later than 6 months after the date on which the coverage of the individual under a health benefits plan commences, reduced by 1 month for each month that the individual was covered under a health insurance plan immediately preceding the date the individual submitted an application for coverage under this Act.

(B) LAPSE IN COVERAGE.—For purposes of this paragraph, a lapse in coverage of not more than 63 days immediately preceding the date of the submission of an application for coverage under this Act shall not be considered a lapse in continuous coverage.

(c) RATES AND PREMIUMS.—

(1) IN GENERAL.—Rates charged and premiums paid for a health benefits plan under this Act—

(A) shall be determined in accordance with this subsection;

(B) may be annually adjusted and differ from such rates charged and premiums paid for the same health benefits plan offered under chapter 89 of title 5, United States Code;

(C) shall be negotiated in the same manner as rates and premiums are negotiated under such chapter 89; and

(D) shall be adjusted to cover the administrative costs of the Office under this Act.

(2) DETERMINATIONS.—In determining rates and premiums under this Act, the following provisions shall apply:

(A) IN GENERAL.—A carrier that enters into a contract under this Act shall determine that amount of premiums to assess for coverage under a health benefits plan based on an community rate that may be annually adjusted—

(i) for the geographic area involved if the adjustment is based on geographical divisions that are not smaller than a metropolitan statistical area;

(ii) based on whether such coverage is for an individual, a married individual with no children, or a family; and

(iii) based on the age of covered individuals (subject to subparagraph (B)).

(B) AGE ADJUSTMENTS.—

(i) IN GENERAL.—With respect to subparagraph (A)(iii), in making adjustments based on age, a carrier may not use age brackets in increments that are smaller than 5 years, which begin not earlier than age 30 and end not later than age 65.

(ii) AGE 65 AND OLDER.—With respect to subparagraph (A)(iii), a carrier may develop separate rates for covered individuals who are 65 years of age or older

for whom medicare is the primary payor for health benefits coverage which is not covered under medicare.

(iii) LIMITATION.—In making an adjustment to premium rates under subparagraph (A)(iii), a carrier shall ensure that such adjustment does not result in an average premium rate applicable to enrollees under the plan involved that is more than 200 percent of the lowest rate for all age groups.

(d) TERMINATION AND REENROLLMENT.—If an individual who is enrolled in a health benefits plan under this Act terminates the enrollment, the individual shall not be eligible for reenrollment until the first open enrollment period following the expiration of 6 months after the date of such termination.

(e) PREEMPTION.—

(1) HEALTH INSURANCE OR PLANS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the terms of any contract entered into under this Act that relate to the nature, provision, or extent of coverage or benefits shall supersede and preempt any State or local law, or any regulation issued thereunder,

which relates to the nature, provision, or extent of coverage or benefits.

(B) LOCAL PLANS.—With respect to a contract entered into under this Act under which a carrier will offer health benefits plan coverage in a limited geographic area, subparagraph (A) shall not apply to the extent that a mandated benefit law is in effect in the State in which the plan is offered. Such mandated benefit law shall continue to apply to such health benefits plan.

(C) RATING RULES.—The rating requirements under subsection (c)(2) shall supercede State rating rules for qualified plans under this Act.

(2) LIMITATION.—Nothing in this subsection shall be construed to preempt—

(A) any State or local law or regulation except those laws and regulations described in subparagraphs (A) and (C) of paragraph (1); and

(B) State network adequacy laws.

(f) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to limit the application of the service-charge system used by the Office for determining profits

for participating carriers under chapter 89 of title 5, United States Code.

SEC. 7. ENCOURAGING PARTICIPATION BY CARRIERS THROUGH ADJUSTMENTS FOR RISK.

(a) APPLICATION OF RISK CORRIDORS.—

(1) IN GENERAL.—This section shall only apply to carriers with respect to health benefits plans offered under this Act during any of calendar years 2006 through 2010.

(2) NOTIFICATION OF COSTS UNDER THE PLAN.—In the case of a carrier that offers a health benefits plan under this Act in any of calendar years 2006 through 2010, the carrier shall notify the Office, before such date in the succeeding year as the Office specifies, of the total amount of costs incurred in providing benefits under the health benefits plan for the year involved and the portion of such costs that is attributable to administrative expenses.

(3) ALLOWABLE COSTS DEFINED.—For purposes of this section, the term ''allowable costs'' means, with respect to a health benefits plan offered by a carrier under this Act, for a year, the total amount of costs described in paragraph (2) for the plan and year, reduced by the portion of such costs

attributable to administrative expenses incurred in providing the benefits described in such paragraph.

(b) ADJUSTMENT OF PAYMENT.—

(1) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN 3 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for a calendar year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year involved, there shall be no payment adjustment under this section for the plan and year.

(2) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE 103 PERCENT OF TARGET AMOUNT.—

(A) COSTS BETWEEN 103 AND 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Office shall reimburse the carrier for such excess costs through payment to the carrier of an amount equal to 75 percent of the difference between such allowable costs and 103 percent of such target amount.

(B) COSTS ABOVE 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are greater than 108 percent of the target amount for the plan and year, the Office shall reimburse the carrier for such excess costs through payment to the carrier in an amount equal to the sum of—

(i) 3.75 percent of such target amount; and

(ii) 90 percent of the difference between such allowable costs and 108 percent of such target amount.

(3) REDUCTION IN PAYMENT IF ALLOWABLE COSTS BELOW 97 PERCENT OF TARGET AMOUNT.—

(A) COSTS BETWEEN 92 AND 97 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the carrier shall be required to pay into the contingency reserve fund maintained under section 8909(b)(2) of title 5, United States Code, an amount equal to 75 percent of the difference

between 97 percent of the target amount and such allowable costs.

(B) COSTS BELOW 92 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are less than 92 percent of the target amount for the plan and year, the carrier shall be required to pay into the stabilization fund under section 8909(b)(2) of title 5, United States Code, an amount equal to the sum of—

(i) 3.75 percent of such target amount; and

(ii) 90 percent of the difference between 92 percent of such target amount and such allowable costs.

(4) TARGET AMOUNT DESCRIBED.—

(A) IN GENERAL.—For purposes of this subsection, the term ''target amount'' means, with respect to a health benefits plan offered by a carrier under this Act in any of calendar years 2006 through 2010, an amount equal to—

(i) the total of the monthly premiums estimated by the carrier and approved by the Office to be paid for enrollees in the

plan under this Act for the calendar year involved; reduced by

(ii) the amount of administrative expenses that the carrier estimates, and the Office approves, will be incurred by the carrier with respect to the plan for such calendar year.

(B) SUBMISSION OF TARGET AMOUNT.—Not later than December 31, 2005, and each December 31 thereafter through calendar year 2009, a carrier shall submit to the Office a description of the target amount for such carrier with respect to health benefits plans provided by the carrier under this Act.

(c) DISCLOSURE OF INFORMATION.—

(1) IN GENERAL.—Each contract under this Act shall provide—

(A) that a carrier offering a health benefits plan under this Act shall provide the Office with such information as the Office determines is necessary to carry out this subsection including the notification of costs under subsection (a)(2) and the target amount under subsection (b)(4)(B); and

(B) that the Office has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Office under such subsections.

(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Office only for the purposes of, and to the extent necessary in, carrying out this section.

SEC. 8. ENCOURAGING PARTICIPATION BY CARRIERS THROUGH REINSURANCE.

(a) ESTABLISHMENT.—The Office shall establish a reinsurance fund to provide payments to carriers that experience one or more catastrophic claims during a year for health benefits provided to individuals enrolled in a health benefits plan under this Act.

(b) ELIGIBILITY FOR PAYMENTS.—To be eligible for a payment from the reinsurance fund for a plan year, a carrier under this Act shall submit to the Office an application that contains—

(1) a certification by the carrier that the carrier paid for at least one episode of care during the year

for covered health benefits for an individual in an amount that is in excess of $50,000; and

(2) such other information determined appropriate by the Office.

(c) PAYMENT.—

(1) IN GENERAL.—The amount of a payment from the reinsurance fund to a carrier under this section for a catastrophic episode of care shall be determined by the Office but shall not exceed an amount equal to 80 percent of the applicable catastrophic claim amount.

(2) APPLICABLE CATASTROPHIC CLAIM AMOUNT.—For purposes of paragraph (1), the applicable catastrophic episode of care amount shall be equal to the difference between—

(A) the amount of the catastrophic claim; and

(B) $50,000.

(3) LIMITATION.—In determining the amount of a payment under paragraph (1), if the amount of the catastrophic claim exceeds the amount that would be paid for the healthcare items or services involved under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Office shall use the

amount that would be paid under such title XVIII for purposes of paragraph (2)(A).

(d) DEFINITION.—In this section, the term ''catastrophic claim'' means a claim submitted to a carrier, by or on behalf of an enrollee in a health benefits plan under this Act, that is in excess of $50,000.

SEC. 9. CONTINGENCY RESERVE FUND.

Beginning on October 1, 2010, the Office may use amounts appropriated under section 14(a) that remain unobligated to establish a contingency reserve fund to provide assistance to carriers offering health benefits plans under this Act that experience unanticipated financial hardships (as determined by the Office).

SEC. 10. EMPLOYER PARTICIPATION.

(a) REGULATIONS.—The Office shall prescribe regulations providing for employer participation under this Act, including the offering of health benefits plans under this Act to employees.

(b) ENROLLMENT AND OFFERING OF OTHER COVERAGE.—

(1) ENROLLMENT.—A participating employer shall ensure that each eligible employee has an opportunity to enroll in a plan under this Act.

(2) PROHIBITION ON OFFERING OTHER COMPREHENSIVE HEALTH BENEFIT COVERAGE.—A par-

ticipating employer may not offer a health insurance plan providing comprehensive health benefit coverage to employees other than a health benefits plan that—

(A) meets the requirements described in section 4(a); and

(B) is offered only through the enrollment process established by the Office under section 3.

(3) OFFER OF SUPPLEMENTAL COVERAGE OPTIONS.—

(A) IN GENERAL.—A participating employer may offer supplementary coverage options to employees.

(B) DEFINITION.—In subparagraph (A), the term ''supplementary coverage'' means benefits described as ''excepted benefits'' under section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

(c) RULE OF CONSTRUCTION.—Except as provided in section 15, nothing in this Act shall be construed to require that an employer make premium contributions on behalf of employees.

SEC. 11. ADMINISTRATION THROUGH REGIONAL ADMINISTRATIVE ENTITIES.

(a) IN GENERAL.—In order to provide for the administration of the benefits under this Act with maximum efficiency and convenience for participating employers and health care providers and other individuals and entities providing services to such employers, the Office is authorized to enter into contracts with eligible entities to perform, on a regional basis, one or more of the following:

(1) Collect and maintain all information relating to individuals, families, and employers participating in the program under this Act in the region served.

(2) Receive, disburse, and account for payments of premiums to participating employers by individuals in the region served, and for payments by participating employers to carriers.

(3) Serve as a channel of communication between carriers, participating employers, and individuals relating to the administration of this Act.

(4) Otherwise carry out such activities for the administration of this Act, in such manner, as may be provided for in the contract entered into under this section.

(5) The processing of grievances and appeals.

(b) APPLICATION.—To be eligible to receive a contract under subsection (a), an entity shall prepare and submit to the Office an application at such time, in such manner, and containing such information as the Office may require.

(c) PROCESS.—

(1) COMPETITIVE BIDDING.—All contracts under this section shall be awarded through a competitive bidding process on a bi-annual basis.

(2) REQUIREMENT.—No contract shall be entered into with any entity under this section unless the Office finds that such entity will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Office finds pertinent.

(3) PUBLICATION OF STANDARDS AND CRITERIA.—The Office shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. In establishing such standards and criteria, the Office shall provide for a system to measure an entity's performance of responsibilities.

(4) TERM.—Each contract under this section shall be for a term of at least 1 year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term, except that the Office may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the entity involved as the Office may provide in regulations) if the Office finds that the entity has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the program established by this Act.

(d) TERMS OF CONTRACT.—A contract entered into under this section shall include—

(1) a description of the duties of the contracting entity;

(2) an assurance that the entity will furnish to the Office such timely information and reports as the Office determines appropriate;

(3) an assurance that the entity will maintain such records and afford such access thereto as the Office finds necessary to assure the correctness and verification of the information and reports under

paragraph (2) and otherwise to carry out the purposes of this Act;

(4) an assurance that the entity shall comply with such confidentiality and privacy protection guidelines and procedures as the Office may require; and

(5) such other terms and conditions not inconsistent with this section as the Office may find necessary or appropriate.

SEC. 12. COORDINATION WITH SOCIAL SECURITY BENEFITS.

Benefits under this Act shall, with respect to an individual who is entitled to benefits under part A of title XVIII of the Social Security Act, be offered (for use in coordination with those medicare benefits) to the same extent and in the same manner as if coverage were under chapter 89 of title 5, United States Code.

SEC. 13. PUBLIC EDUCATION CAMPAIGN.

(a) IN GENERAL.—In carrying out this Act, the Office shall develop and implement an educational campaign to provide information to employers and the general public concerning the health insurance program developed under this Act.

(b) ANNUAL PROGRESS REPORTS.—Not later than 1 year and 2 years after the implementation of the campaign

under subsection (a), the Office shall submit to the appropriate committees of Congress a report that describes the activities of the Office under subsection (a), including a determination by the office of the percentage of employers with knowledge of the health benefits programs provided for under this Act.

(c) PUBLIC EDUCATION CAMPAIGN.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2006 and 2007.

SEC. 14. APPROPRIATIONS.

(a) MANDATORY APPROPRIATIONS.—There are authorized to be appropriated, and there are appropriated, to carry out sections 7 and 8—

(1) $4,000,000,000 for fiscal year 2006;

(2) $4,000,000,000 for fiscal year 2007;

(3) $4,000,000,000 for fiscal year 2008;

(4) $3,000,000,000 for fiscal year 2009; and

(5) $3,000,000,000 for fiscal year 2010.

(b) OTHER APPROPRIATIONS.—There are authorized to be appropriated to the Office, such sums as may be necessary in each fiscal year for the development and administration of the program under this Act.

SEC. 15. REFUNDABLE CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and inserting after section 35 the following new section:

"SEC. 36. SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.

"(a) DETERMINATION OF AMOUNT.—In the case of a qualified small employer, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the sum of—

"(1) the expense amount described in subsection (b), and

"(2) the expense amount described in subsection (c), paid by the taxpayer during the taxable year.

"(b) SUBSECTION (b) EXPENSE AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—The expense amount described in this subsection is the applicable percentage of the amount of qualified employee health insurance expenses of each qualified employee.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The applicable percentage is equal to—

"(i) 25 percent in the case of self-only coverage,

"(ii) 35 percent in the case of family coverage (as defined in section 220(c)(5)), and

"(iii) 30 percent in the case of coverage for married adults with no children.

"(B) BONUS FOR PAYMENT OF GREATER PERCENTAGE OF PREMIUMS.—The applicable percentage otherwise specified in subparagraph (A) shall be increased by 5 percentage points for each additional 10 percent of the qualified employee health insurance expenses of each qualified employee exceeding 60 percent which are paid by the qualified small employer.

"(c) SUBSECTION (c) EXPENSE AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—The expense amount described in this subsection is, with respect to the first credit year of a qualified small employer which is an eligible employer, 10 percent of the qualified employee health insurance expenses of each qualified employee.

''(2) FIRST CREDIT YEAR.—For purposes of paragraph (1), the term 'first credit year' means the taxable year which includes the date that the health insurance coverage to which the qualified employee health insurance expenses relate becomes effective.

''(3) ELIGIBLE EMPLOYER.—For purposes of paragraph (1), the term 'eligible employer' shall not include a qualified small employer if, during the 3-taxable year period immediately preceding the first credit year, the employer or any member of any controlled group including the employer (or any predecessor of either) established or maintained health insurance coverage for substantially the same employees as are the qualified employees to which the qualified employee health insurance expenses relate.

''(d) LIMITATION BASED ON WAGES.—

''(1) IN GENERAL.—The percentage which would (but for this subsection) be taken into account as the percentage for purposes of subsection (b)(2) or (c)(1) for the taxable year shall be reduced (but not below zero) by the percentage determined under paragraph (2).

''(2) AMOUNT OF REDUCTION.—

''(A) IN GENERAL.—The percentage determined under this paragraph is the percentage

which bears the same ratio to the percentage which would be so taken into account as—

"(i) the excess of—

"(I) the qualified employee's wages at an annual rate during such taxable year, over

"(II) $25,000, bears to

"(ii) $5,000.

"(B) ANNUAL ADJUSTMENT.—For each taxable year after 2006, the dollar amounts specified for the preceding taxable year (after the application of this subparagraph) shall be increased by the same percentage as the average percentage increase in premiums under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code for the calendar year in which such taxable year begins over the preceding calendar year.

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

"(1) QUALIFIED SMALL EMPLOYER.—The term 'qualified small employer' means any employer (as defined in section 2(b)(2) of the Small Employers Health Benefits Program Act of 2005) which—

"(A) is a participating employer (as defined in section 2(b)(5) of such Act), and

''(B) pays or incurs at least 60 percent of the qualified employee health insurance expenses of each qualified employee.

''(2) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

''(A) IN GENERAL.—The term 'qualified employee health insurance expenses' means any amount paid by an employer for health insurance coverage under such Act to the extent such amount is attributable to coverage provided to any employee while such employee is a qualified employee.

''(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account under subparagraph (A).

''(3) QUALIFIED EMPLOYEE.—

''(A) IN GENERAL.—The term 'qualified employee' means, with respect to any period, an employee (as defined in section 2(b)(1) of such Act) of an employer if the total amount of wages paid or incurred by such employer to

such employee at an annual rate during the taxable year exceeds $5,000.

''(B) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(f) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

''(g) CREDITS FOR NONPROFIT ORGANIZATIONS.—Any credit which would be allowable under subsection (a) with respect to a qualified small business if such qualified small business were not exempt from tax under this chapter shall be treated as a credit allowable under this subpart to such qualified small business.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

''Sec. 36. Small business employee health insurance expenses
''Sec. 37. Overpayments of tax''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2005.

SEC. 16. EFFECTIVE DATE.

Except as provided in section 10(e), this Act shall take effect on the date of enactment of this Act and shall apply to contracts that take effect with respect to calendar year 2006 and each calendar year thereafter.

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