I

110TH CONGRESS
2D SESSION

H. R. 5918

To amend the Public Health Service Act to establish a nationwide health insurance purchasing pool for small businesses and the self-employed that would offer a choice of private health plans and make health coverage more affordable, predictable, and accessible.

IN THE HOUSE OF REPRESENTATIVES

APRIL 29, 2008

Mr. BARROW introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, Ways and Means, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act to establish a nationwide health insurance purchasing pool for small businesses and the self-employed that would offer a choice of private health plans and make health coverage more affordable, predictable, and accessible.

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 Business Health Options Program Act of 2008'' or the ''SHOP Act''.

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXX—SMALL BUSINESS HEALTH OPTIONS PROGRAM

"SEC. 3001. DEFINITIONS.

''(a) IN GENERAL.—In this title:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator appointed under section 3002(a).

''(2) SMALL BUSINESS HEALTH BOARD.—The term 'Small Business Health Board' means the Board established under section 3002(d).

''(3) 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.

''(4) 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 employers who employed an average of at least 1 but not more than 100 employees (who worked an average of at least 35 hours per week) on business

days during the year preceding the date of application, and shall include self-employed individuals with either not less than $5,000 in net earnings or not less than $15,000 in gross earnings from self-employment in the preceding taxable year. Such term shall not include the Federal Government.

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

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791.

''(7) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

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

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

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

''(b) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of subsection (a)(3):

''(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 (a)(4) 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.

''(c) WAIVER AND CONTINUATION OF PARTICIPATION.—

''(1) WAIVER.—The Administrator may waive the limitations relating to the size of an employer which may participate in the health insurance program established under this title on a case by case basis if the Administrator determines that such employer makes a compelling case for such a waiver. In

making determinations under this paragraph, the Administrator 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 title 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.

''(d) TREATMENT OF HEALTH INSURANCE COVERAGE AS GROUP HEALTH PLAN.—Health insurance coverage offered under this title shall be treated as a group health plan for purposes of applying the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) except to the extent that a provision of this title expressly provides otherwise.

''(e) APPLICATION OF HIPAA RULES.—Notwithstanding any provision of State law, the provisions of subparts 1, 3, and 4 of part A of title XXVII shall apply to health insurance coverage offered under this title. A State may modify State law as appropriate to provide for the enforcement of such provisions for health insurance coverage offered in the State under this title.

"SEC. 3002. ADMINISTRATION OF SMALL BUSINESS HEALTH INSURANCE POOL.

''(a) OFFICE AND ADMINISTRATOR.—The Secretary shall designate an office within the Department of Health and Human Services to administer the program under this title. Such office shall be headed by an Administrator to be appointed by the Secretary.

''(b) QUALIFICATIONS.—The Secretary shall ensure that the individual appointed to serve as the Administrator under subsection (a) has an appropriate background with experience in health insurance, business, or health policy.

''(c) DUTIES.—The Administrator shall—

''(1) enter into contracts with health insurance issuers to provide health insurance coverage to individuals and employees who enroll in health insurance coverage in accordance with this title;

''(2) maintain the contracts for health insurance policies when an employee elects which health plan offered under this title to enroll in as permitted under section 3007(d)(7);

''(3) ensure that health insurance issuers comply with the requirements of this title;

''(4) ensure that employers meet eligibility requirements for participation in the health insurance pool established under this title;

''(5) enter into agreements with entities to serve as navigators, as defined in section 3003;

''(6) collect premiums from employers and employees and make payments for health insurance coverage;

''(7) collect other information needed to administer the program under this title;

''(8) compile, produce, and distribute information (which shall not be subject to review or modification by the States) to employers and employees (directly and through navigators) concerning the open enrollment process, the health insurance coverage available through the pool, and standardized comparative information concerning such coverage, which shall be available through an interactive Internet website, including a description of the coverage plans available in each State and comparative information, about premiums, index rates, benefits, quality, and consumer satisfaction under such plans;

''(9) provide information to health insurance issuers, including, at the discretion of the Administrator, notification when proposed rates are not in a competitive range;

''(10) conduct public education activities (directly and through navigators) to raise the aware-

ness of the public of the program under this title and the associated tax credit under the Internal Revenue Code of 1986;

''(11) develop methods to facilitate enrollment in health insurance coverage under this title, including through the use of the Internet;

''(12) if appropriate, enter into contracts for the performance of administrative functions under this title as permitted under section 3009;

''(13) carefully consider benefit recommendations that are endorsed by at least two-thirds of the members of the Small Business Health Board;

''(14) establish and administer a contingency fund for risk corridors as provided for in section 3008; and

''(15) carry out any other activities necessary to administer this title.

''(d) LIMITATIONS.—The Administrator shall not—

''(1) negotiate premiums with participating health insurance issuers; or

''(2) exclude health insurance issuers from participating in the program under this title except for violating contracts or the requirements of this title.

''(e) SMALL BUSINESS HEALTH BOARD.—

''(1) IN GENERAL.—There shall be established a Small Business Health Board to monitor the implementation of the program under this title and to make recommendations to the Administrator concerning improvements in the program.

''(2) APPOINTMENT.—The Comptroller General shall appoint 13 individuals who have expertise in health care benefits, financing, economics, actuarial science or other related fields, to serve as members of the Small Business Health Board. In appointing members under the preceding sentence, the Comptroller General shall ensure that such members include—

''(A) a mix of different types of professionals;

''(B) a broad geographic representation;

''(C) not less than 3 individuals with an employee perspective;

''(D) not less than 3 individuals with a small business perspective, at least 1 of whom shall have a self-employed perspective; and

''(E) not less than 1 individual with a background in insurance regulation.

''(3) TERMS.—Members of the Small Business Health Board shall serve for a term of 3 years, such

terms to end on March 15 of the applicable year, except as provided in paragraph (4). The Comptroller General shall stagger the terms for members first appointed. A member may be reappointed after the expiration of a term. A member may serve after expiration of a term until a successor has been appointed.

''(4) SMALL BUSINESS REPRESENTATIVES.—Beginning on March 16, 2012, 3 of the individuals the Comptroller General appoints to the Small Business Health Board shall be representatives of the 3 navigators through which the largest number of individuals have enrolled for health insurance coverage over the previous 2-year period. Such appointees shall serve for 1 year. The Comptroller General shall consider for appointment in years prior to the date specified in this paragraph, individuals who are representatives of entities that may serve as navigators.

''(5) CHAIRPERSON; VICE CHAIRPERSON.—The Comptroller General shall designate a member of the Small Business Health Board, at the time of appointment of such member, to serve as Chairperson and a member to serve as Vice Chairperson for the term of the appointment, except that in the case of a vacancy of either such position, the Comptroller

General may designate another member to serve in such position for the remainder of such member's term.

''(6) COMPENSATION.—While serving on the business of the Small Business Health Board (including travel time), a member of the Small Business Health Board shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairperson of the Small Business Health Board.

''(7) DISCLOSURE.—The Comptroller General shall establish a system for the public disclosure, by members of the Small Business Health Board, of financial and other potential conflicts of interest.

''(8) MEETINGS.—The Small Business Health Board shall meet at the call of the Chairperson. Each such meeting shall be open to the public.

''(9) DUTIES.—The Small Business Health Board shall—

''(A) provide general oversight of the program under this title and make recommendations to the Administrator;

''(B) monitor and make recommendations to the Administrator on the benefit requirements for national plans in this title;

''(C) make recommendations concerning information that the Administrator, health plans, and navigators should distribute to employers and employees participating in the program under this title; and

''(D) monitor and make recommendations to the Administrator on adverse selection within the program under this title and between the coverage provided under the program and the State-regulated health insurance market.

''(10) APPROVAL OF RECOMMENDATIONS.—A recommendation shall require approval by not less than two-thirds of the members of the Board.

''(11) PUBLIC NOTICE AND COMMENT ON RECOMMENDATIONS.—The Administrator shall—

''(A) publish recommendations by the Small Business Health Board in the Federal Register;

''(B) solicit written comments concerning such recommendations; and

''(C) provide an opportunity for the presentation of oral comments concerning such recommendations at a public meeting.

''SEC. 3003. NAVIGATORS.

''(a) IN GENERAL.—The Administrator shall enter into agreements with private and public entities, beginning a reasonable period prior to the beginning of the first calendar year in which health insurance coverage is offered under this title, under which such entities will serve as navigators.

''(b) ELIGIBILITY.—To be eligible to enter into an agreement under subsection (a), an entity shall demonstrate to the Administrator that the entity has existing relationships with, or could readily establish relationships with, employers and employees, and self-employed individuals, likely to be eligible to participate in the program under this title. Such entities may include trade, industry and professional associations, chambers of commerce, unions, small business development centers, and other entities that the Administrator determines to be capable of carrying out the duties described in subsection (c).

''(c) DUTIES.—An entity that serves as a navigator under an agreement under subsection (a) shall—

''(1) coordinate with the Administrator on public education activities to raise awareness of the program under this title;

''(2) distribute information developed by the Administrator on the open enrollment process, private health plans available through the program under this title, and standardized comparative information about the health insurance coverage under the program;

''(3) distribute information about the availability of the tax credit under section 36 of the Internal Revenue Code of 1986 as added by the Small Business Health Options Program Act of 2008;

''(4) assist employers and employees in enrolling in the program under this title; and

''(5) respond to questions about the program under this title and participating plans.

''(d) SUPPLEMENTAL MATERIALS.—In addition to information developed by the Administrator under subsection (c)(2), a navigator may develop and distribute other information that is related to the health insurance program established under this title, subject to review and approval by the Administrator and filing in each State in which the navigator operates.

''(e) STANDARDS.—

''(1) IN GENERAL.—The Administrator shall establish standards for navigators under this section, including provisions to avoid conflicts of interest. Under such standards, a navigator may not—

''(A) be a health insurance issuer; or

''(B) receive any consideration directly or indirectly from any health insurance issuer in connection with the participation of any employer in the program under this title or the enrollment of any eligible employee in health insurance coverage under this title.

''(2) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Administrator shall consult with the Small Business Health Board concerning the standards necessary to ensure that a navigator will provide fair and impartial information and services. An agreement between the Administrator and a navigator may include specific provisions with respect to such navigator to ensure that such navigator will provide fair and impartial information and services. If a navigator, or entity seeking to become a navigator, is a party to any arrangement with any health insurance issuer to receive compensation related to other health care programs not covered under this title, the entity shall disclose the terms of such com-

pensation arrangements to the Administrator, and the Administrator shall take such information into account in determining the appropriate standards and agreement terms for such navigator.

"SEC. 3004. CONTRACTS WITH HEALTH INSURANCE ISSUERS.

"(a) IN GENERAL.—The Administrator may enter into contracts with qualified health insurance issuers, without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to provide health benefits plans to employees of participating employers and self-employed individuals under this title. 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 Administrator shall ensure that health benefits coverage is provided for an individual only, two adults in a household, one adult and one or more children, and a family.

"(b) ELIGIBILITY.—A health insurance issuer shall be eligible to enter into a contract under subsection (a) if such issuer—

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

''(2) meets such other reasonable requirements as determined appropriate by the Administrator, after an opportunity for public comment and publication in the Federal Register.

''(c) COST-SHARING AND NETWORKS.—The Administrator shall ensure that health benefits plans with a range of cost-sharing and network arrangements are available under this title.

''(d) REVOCATION.—Approval of a health benefits plan participating in the program under this title may be withdrawn or revoked by the Administrator only after notice to the health insurance issuer involved and an opportunity for a hearing without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

''(e) CONVERSION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a contract may not be made or a plan approved under this section if the health insurance issuer under such contract or plan does not provide to each enrollee whose coverage under the plan is terminated, including a termination due to discontinuance of the contract or plan, the option to have issued to that individual a nongroup policy without evidence of insurability. A health insurance issuer shall provide a notice of such option to indi-

viduals who enroll in the plan. An enrollee who exercises such conversion option shall pay the full periodic charges for the nongroup policy.

''(2) EXCEPTIONS.—A health insurance issuer shall not be required to offer a nongroup policy under paragraph (1) if the termination under the plan occurred because—

''(A) the enrollee failed to pay any required monthly premiums under the plan;

''(B) the enrollee performed an act or practice that constitutes fraud in connection with the coverage under the plan;

''(C) the enrollee made an intentional misrepresentation of a material fact under the terms of coverage of the plan; or

''(D) the terminated coverage under the plan was replaced by similar coverage within 31 days after the date of termination.

''(f) PAYMENT OF PREMIUMS.—

''(1) IN GENERAL.—Employers shall collect premium payments from their employees through payroll deductions and shall forward such payments and the contribution of the employer (if any) to the Administrator. The Administrator shall develop procedures through which such payments shall be received

and forwarded to the health insurance issuer involved.

''(2) FAILURE TO PAY.—

''(A) IN GENERAL.—Failure to pay premiums shall be treated as a debt owed to the United States in the same manner as the failure to repay a loan made to an individual under the Higher Education Act of 1965 is treated as such a debt.

''(B) PROCEDURES.—The Administrator shall establish procedures—

''(i) for the termination of employers that fail, for a two consecutive month period (or such other time period as determined appropriate by the Administrator), to make premium payments in a timely manner; and

''(ii) for recovering the cost of unpaid and uncollected premiums through an adjustment in the rates charged for the subsequent year in accordance with section 3007(b)(1)(C).

''SEC. 3005. EMPLOYER PARTICIPATION.

''(a) PARTICIPATION PROCEDURE.—The Administrator shall develop a procedure for employers and self-

employed individuals to participate in the program under this title, including procedures relating to the offering of health benefits plans to employees and the payment of premiums for health insurance coverage under this title. For the purpose of premium payments, a self-employed individual shall be considered an employer that is making a 100 percent contribution toward the premium amount.

''(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 of the employer's choice or a plan of the employee's choice in accordance with section 3007(d)(7).

''(2) PROHIBITION ON OFFERING OTHER COMPREHENSIVE HEALTH BENEFIT COVERAGE.—A participating employer may not offer a health insurance plan providing comprehensive health benefit coverage to employees other than a health benefits plan offered under this title.

''(3) PROHIBITION ON COERCION.—An employer shall not pressure, coerce, or offer inducements to an employee to elect not to enroll in coverage under the program under this title or to select a particular health benefits plan.

''(4) 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).

''(c) REGULATORY FLEXIBILITY.—In developing the procedure under subsection (a), the Administrator shall comply with the requirements specified under the Regulatory Flexibility Act under chapter 6 of title 5, United States Code, consider the economic impacts that the regulation will have on small businesses, and consider regulatory alternatives that would mitigate such impact. The Administrator shall publish and publicly disseminate a small business compliance guide, pursuant to section 212 of the Small Business Regulatory Enforcement Fairness Act, that explains the compliance requirements for employer participation. Such compliance guide shall be published not later than the date of the publication of the final rule under this title, or the effective date of such rules, whichever is later.

''(d) RULE OF CONSTRUCTION.—Except as provided in section 3004(f), nothing in this title shall be construed to require that an employer make premium contributions on behalf of employees.

''SEC. 3006. ELIGIBILITY AND ENROLLMENT.

''(a) IN GENERAL.—An individual shall be eligible to enroll in health insurance coverage under this title for coverage beginning in 2011 if such individual is an employee of a participating employer described in section 3001(a)(4) or is a self-employed individual as defined in section 401(c)(1)(B) of the Internal Revenue Code of 1986 and meets the definition of a participating employer in section 3001(a)(8). An employer may allow employees who average fewer than 35 hours per week to enroll.

''(b) LIMITATION.—A health insurance issuer may not refuse to provide coverage to any eligible individual under subsection (a) who selects a health benefits plan offered by such issuer under this title.

''(c) TYPE OF ENROLLMENT.—An eligible individual may enroll as an individual or as an adult with one or more children regardless of whether another adult is present in the enrollee's household or family.

''(d) OPEN ENROLLMENT.—

''(1) IN GENERAL.—The Administrator shall establish an annual open enrollment period during

which an employer may elect to become a participating employer and an employee may enroll in a health benefits plan under this title for the following calendar year.

''(2) OPEN ENROLLMENT PERIOD.—For purposes of this title, the term 'open enrollment period' means, with respect to calendar year 2011 and each succeeding calendar year, the period beginning on October 1, 2010, and ending December 1, 2010, and each succeeding period beginning October 1 and ending December 1. Coverage in a health benefits plan selected during such an open enrollment period shall begin on January 1 of the calendar year following the selection.

''(3) NEWLY ELIGIBLE EMPLOYERS AND EMPLOYEES.—Notwithstanding the open enrollment period provided for under paragraph (2), the Administrator shall establish an enrollment process to enable a newly eligible employer or an employer with an existing health benefits policy whose term is ending to become a participating employer and for an employee of such employer, or a new employee of a participating employer, to enroll in a health benefits plan under this title outside of an open enrollment period. The Administrator may establish a process

for setting the renewal date for the participation of an employer that initially becomes a participating employer outside of the open enrollment period to coincide with a subsequent open enrollment period.

''(4) LIMITATION OF CHANGING ENROLLMENT.—An employer or employee (as the case may be) may elect to change the health benefits plan that the employee is enrolled in only during an open enrollment period.

''(5) EFFECTIVENESS OF ELECTION AND CHANGE OF ELECTION.—An election to change a health benefits plan that is made during the open enrollment period under paragraph (2) shall take effect as of the first day of the following calendar year.

''(6) CONTINUATION OF ENROLLMENT.—An employee who has enrolled in a health benefits plan under this title is considered to have been continuously enrolled in that health benefits plan until such time as—

''(A) the employer or employee (as the case may be) elects to change health benefits plans; or

''(B) the health benefits plan is terminated.

''(e) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—The Administrator shall compile, produce, and disseminate information to employers, employees, and navigators under section 3002(c)(8) to promote informed choice that shall be made available at least 30 days prior to the beginning of each open enrollment period.

''(f) TERMINATION OF EMPLOYMENT.—An employee may remain enrolled in a health plan under this title for the remainder of the calendar year following the termination or separation of the employee from employment or termination of the employer, if the employee pays 100 percent of the monthly premium for the remainder of the year involved.

''(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health insurance issuer providing coverage through the program under this title from using the services of a licensed agent or broker.

"SEC. 3007. HEALTH COVERAGE AVAILABLE WITHIN THE SMALL BUSINESS POOL.

''(a) PREEXISTING CONDITION EXCLUSIONS.—

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

''(2) EXCLUSION PERIOD.—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 the aggregate of 1 day for each day that the individual was covered under creditable health insurance coverage (as defined for purposes of section 2701(c)) immediately preceding the date the individual submitted an application for coverage under this title. This provision shall be applied notwithstanding the applicable provision for the reduction of the exclusion period provided for in section 701(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(3)).

''(b) RATES AND PREMIUMS; STATE LAWS.—

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

''(A) shall be determined in accordance with subsection (d);

''(B) may be annually adjusted; and

''(C) shall be adjusted to cover the administrative costs of the Administrator under this

title and the office established under section 3002.

''(2) BENEFIT MANDATE LAWS.—With respect to a contract entered into under this title under which a health insurance issuer will offer health benefits plan coverage, State mandated benefit laws in effect in the State in which the plan is offered shall continue to apply, except in the case of a nationwide plan.

''(3) LIMITATION.—Nothing in this subsection shall be construed to preempt any State or local law (including any State grievance, claims, and appeals procedure laws, State provider mandate laws, and State network adequacy laws) except those laws and regulations described in subsection (b)(2), (d)(2)(B), and (d)(5).

''(c) TERMINATION AND REENROLLMENT.—If an individual who is enrolled in a health benefits plan under this title voluntarily terminates the enrollment, except in the case of an individual who has lost or changes employment or whose employer is terminated for failure to pay premiums, 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.

''(d) RATING RULES AND TRANSITIONAL APPLICATION OF STATE LAW.—

''(1) YEARS 2011 AND 2012.—With respect to calendar years 2011 and 2012 (open enrollment period beginning October 1, 2010, and October 1, 2011), the following shall apply:

''(A) In the case of an employer that elects to participate in the program under this title, the State rating requirements applicable to employers purchasing health insurance coverage in the small group market in the State in which the employer is located shall apply with respect to such coverage, except that premium rates for such coverage shall not vary based on health-status related factors.

''(B) State rating requirements shall apply to health insurance coverage purchased in the small group market in the State, except that a State shall be prohibited from allowing premium rates to vary based on health-status related factors.

''(2) SUBSEQUENT YEARS.—

''(A) NAIC RECOMMENDATIONS.—

''(i) STUDY.—Beginning in 2009, the Administrator shall contract with the Na-

tional Association of Insurance Commissioners to conduct a study of the rating requirements utilized in the program under this title and the rating requirements that apply to health insurance purchased in the small group markets in the States, and to develop recommendations concerning rating requirements. Such recommendations shall be submitted to the appropriate committees of Congress during calendar year 2011.

''(ii) CONSULTATION.—In conducting the study under clause (i), the National Association of Insurance Commissioners shall consult with key stakeholders (including small businesses, self-employed individuals, employees of small businesses, health insurance issuers, health care providers, and patient advocates).

''(iii) RECOMMENDATIONS.—During calendar year 2011, the recommendations of the National Association of Insurance Commissioners shall be submitted to Congress (in the form of a legislative proposal), and shall concern—

"(I) rating requirements for health insurance coverage under this title for calendar year 2013 and subsequent calendar years; and

"(II) a maximum permissible variance between State rating requirements and the rating requirements for coverage under this title that will allow State flexibility without causing significant adverse selection for health insurance coverage under this title.

"(B) APPLICATION OF REQUIREMENTS.—If, pursuant to this subsection, an Act is enacted to implement rating requirements pursuant to the recommendations submitted under subparagraph (A), or alternative rating requirements developed by Congress, such rating requirements shall apply to the program under this title beginning in calendar year 2013 (open enrollment periods beginning October 1, 2012, and thereafter).

"(3) FAILURE TO ENACT LEGISLATION.—If an Act is not enacted as provided for in paragraph (2)(B), the fallback rating rules under paragraph (5) shall apply beginning in calendar year 2013

(open enrollment periods beginning October 1, 2012, and thereafter).

"(4) EXPEDITED CONGRESSIONAL CONSIDERATION.—

"(A) INTRODUCTION AND COMMITTEE CONSIDERATION.—

"(i) INTRODUCTION.—A legislative proposal submitted to Congress pursuant to paragraph (2) shall be introduced in the House of Representatives by the Speaker, and in the Senate by the majority leader, immediately upon receipt of the language and shall be referred to the appropriate committees of Congress. If the proposal is not introduced in accordance with the preceding sentence, legislation may be introduced in either House of Congress by any member thereof.

"(ii) COMMITTEE CONSIDERATION.—Legislation introduced in the House of Representatives and the Senate under clause (i) shall be referred to the appropriate committees of jurisdiction of the House of Representatives and the Senate. Not later than 45 calendar days after the

introduction of the legislation or February 15th, 2012, whichever is later, the committee of Congress to which the legislation was referred shall report the legislation or a committee amendment thereto. If the committee has not reported such legislation (or identical legislation) at the end of 45 calendar days after its introduction, or February 15th, 2012, whichever is later, such committee shall be deemed to be discharged from further consideration of such legislation and such legislation shall be placed on the appropriate calendar of the House involved.

''(B) EXPEDITED PROCEDURE.—

''(i) CONSIDERATION.—Not later than 15 calendar days after the date on which a committee has been or could have been discharged from consideration of legislation under this paragraph, the Speaker of the House of Representatives, or the Speaker's designee, or the majority leader of the Senate, or the leader's designee, shall move to proceed to the consideration of the committee amendment to the legislation, and if

there is no such amendment, to the legislation. It shall also be in order for any member of the House of Representatives or the Senate, respectively, to move to proceed to the consideration of the legislation at any time after the conclusion of such 15-day period. All points of order against the legislation (and against consideration of the legislation) with the exception of points of order under the Congressional Budget Act of 1974 are waived. A motion to proceed to the consideration of the legislation is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the legislation, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives or the Senate, as the case may be, shall immediately proceed to consideration of the legislation in ac-

cordance with the Standing Rules of the House of Representatives or the Senate, as the case may be, without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives or the Senate, as the case may be, until disposed of, except as provided in clause (iii).

''(ii) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the legislation that was introduced in such House, such House receives from the other House legislation as passed by such other House—

''(I) the legislation of the other House shall not be referred to a committee and shall immediately displace the legislation that was introduced in the House in receipt of the legislation of the other House; and

''(II) the legislation of the other House shall immediately be considered by the receiving House under the same procedures applicable to legisla-

tion reported by or discharged from a committee under this paragraph.

''Upon disposition of legislation that is received by one House from the other House, it shall no longer be in order to consider the legislation that was introduced in the receiving House.

''(iii) SENATE VOTE REQUIREMENT.—Legislation under this paragraph shall only be approved in the Senate if affirmed by the votes of 3/5 of the Senators duly chosen and sworn. If legislation in the Senate has not reached final passage within 10 days after the motion to proceed is agreed to (excluding periods in which the Senate is in recess) it shall be in order for the majority leader to file a cloture petition on the legislation or amendments thereto, in accordance with rule XXII of the Standing Rules of the Senate. If such a cloture motion on the legislation fails, is shall be in order for the majority leader to proceed to other business and the legislation shall be returned to or placed on the Senate calendar.

"(iv) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the legislation that results in a disagreement between the two Houses of Congress with respect to the legislation, conferees shall be appointed and a conference convened. Not later than 15 days after the date on which conferees are appointed (excluding periods in which one or both Houses are in recess), the conferees shall file a report with the House of Representatives and the Senate resolving the differences between the Houses on the legislation. Notwithstanding any other rule of the House of Representatives or the Senate, it shall be in order to immediately consider a report of a committee of conference on the legislation filed in accordance with this subclause. Debate in the House of Representatives and the Senate on the conference report shall be limited to 10 hours, equally divided and controlled by the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees and the

majority and minority leaders of the Senate or their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report. The conference report shall be approved in the Senate only if affirmed by the votes of 3/5 of the Senators duly chosen and sworn.

''(C) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This paragraph is enacted by Congress—

''(i) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of legislation under this paragraph, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

''(ii) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the pro-

cedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

''(5) FALLBACK RATING RULES.—For purposes of paragraph (3), the fallback rating rules are as follows:

''(A) PROGRAM.—

''(i) RATING RULES.—A health insurance issuer that enters into a contract under the program under this title shall determine the amount of premiums to assess for coverage under a health benefits plan based on a community rate that may be annually adjusted only—

''(I) based on the age of covered individuals (subject to clause (iii));

''(II) based on the geographic area involved if the adjustment is based on geographical divisions that are not smaller than a metropolitan statistical area and the issuer provides evidence of geographic variation in cost of services;

''(III) based on industry (subject to clause (iv));

''(IV) based on tobacco use; and

''(V) based on whether such coverage is for an individual, 2 adults in a household, 1 adult and 1 or more children, or a family.

''(ii) LIMITATION.—Premium rates charged for coverage under the program under this title shall not vary based on health-status related factors, gender, class of business, or claims experience or any other factor not described in clause (i).

''(iii) AGE ADJUSTMENTS.—

''(I) IN GENERAL.—With respect to clause (i)(I), in making adjustments based on age, the Administrator shall establish not more than 5 age brackets to be used by a health insurance issuer in establishing rates for individuals under the age of 65. The rates for any age bracket shall not exceed 300 percent of the rate for the lowest age bracket. Age-related premiums may not vary within age brackets.

"(II) AGES 65 AND OLDER.—With respect to clause (i)(I), a health insurance issuer may develop separate rates for covered individuals who are 65 years of age or older for whom the primary payor for health benefits coverage is the medicare program under title XVIII of the Social Security Act, for the coverage of health benefits that are not otherwise covered under medicare.

"(iv) INDUSTRY ADJUSTMENT.—With respect to clause (i)(III), in making adjustments based on industry, the rates for any industry shall not exceed 115 percent of the rate for the lowest industry and shall be based on evidence of industry variation in cost of services.

"(B) STATE RATING RULES.—State rating requirements shall apply to health insurance coverage purchased in the small group market, except that a State shall not permit premium rates to vary based on health-status related factors.

''(6) STATE WITH LESS PREMIUM VARIATION.—Effective beginning in calendar year 2013, in the case of a State that provides a rating variance with respect to age that is less than the Federal limit established under paragraph (2)(B) or (3) or that provides for some form of community rating, or that provides a rating variance with respect to industry that is less than the Federal limit established under paragraph (2)(B) or (3), or that provides a rating variance with respect to the geographic area involved that is less than the Federal limit established in paragraph (2)(B) or (3), premium rates charged for health insurance coverage under this title in such State with respect to such factor shall reflect the rating requirements of such State.

''(7) EMPLOYEE CHOICE.—

''(A) CALENDAR YEARS 2011 AND 2012.—With respect to calendar years 2011 and 2012 (open enrollment periods beginning October 1, 2010, and October 1, 2011), in the case of a State that applies community rating or adjusted community rating where any age bracket does not exceed 300 percent of the lowest age bracket, employees of an employer located in that

State may elect to enroll in any health plan offered under this title.

''(B) SUBSEQUENT YEARS.—Beginning in calendar year 2013 (open enrollment periods beginning October 1, 2012, and thereafter), employees of an employer that participates in the program under this title may elect to enroll in any health plan offered under this title.

''(C) EXCEPTION.—In any State or year in which an employee is not able to select a health plan as provided for in subparagraph (A) or (B), the employer shall select the health plan or plans that shall be made available to the employees of such employer.

''(8) STATE APPROVAL OF RATES.—State laws requiring the approval of rates with respect to health insurance shall continue to apply to health insurance coverage under this title in such State unless the State fails to enforce the application of rates that would otherwise apply to health insurance issuers under the program under this title.

''(e) BENEFITS.—

''(1) STATEMENT OF BENEFITS.—Each contract under this title shall contain a detailed statement of benefits offered and shall include informa-

tion concerning such maximums, limitations, exclusions, and other definitions of benefits as the Administrator considers necessary or reasonable.

''(2) NATIONWIDE PLANS.—

''(A) IN GENERAL.—In the case of contracts with health insurance issuers that offer a health benefit plan on a nationwide basis, in the first year after the date of enactment of this title, the benefit package shall include benefits established by the Administrator.

''(B) PROCESS FOR ESTABLISHING BENEFITS FOR NATIONWIDE PLANS.—The benefits provide for under subparagraph (A) shall be determined as follows:

''(i) Not later than 30 days after the date of enactment of this title, the Secretary shall enter into a contract with the Institute of Medicine to develop a minimum set of benefits to be offered by nationwide plans.

''(ii) In developing such minimum set of benefits, the Institute of Medicine shall convene public forums to allow input from key stakeholders (including small businesses, self-employed individuals, employ-

ees of small businesses, health insurance issuers, insurance regulators, health care providers, and patient advocates) and shall consult with the Small Business Health Board.

''(iii) The Institute of Medicine shall consider—

''(I) the clinical appropriateness and effectiveness of the benefits covered;

''(II) the affordability of the benefits covered;

''(III) the financial protection of enrollees against high health care expenses;

''(IV) access to necessary health care services; and

''(V) benefits similar to those available in the small group market on the date of enactment of this title.

''(iv) The benefits package shall not be discriminatory or be likely to promote or induce adverse selection.

''(v) The Administrator shall publish the benefits recommended by the Institute of Medicine for public comment.

''(vi) Based on the comments received, the Administrator may make changes only to the extent that the recommendation from the Institute of Medicine is not consistent with the criteria contained in clause (iii) or there is a compelling need for the changes to ensure the effective functioning of the program.

''(C) CHANGES TO BENEFITS.—

''(i) IN GENERAL.—By a vote of a two-thirds majority, the Small Business Health Board may recommend to the Administrator changes to the benefit package for nationwide plans under this paragraph for years subsequent to the first year in which such benefits are in effect.

''(ii) REDUCTION IN BENEFITS.—The Administrator may reduce benefits that were previously covered under this paragraph only if—

''(I) two-thirds of the Small Business Health Board recommend such change; or

''(II) there is a compelling need for the change to prevent a substantial reduction in participation in the program under this title.

''(f) ADDITIONAL PREMIUM FOR DELAYED ENROLLMENT.—

''(1) IN GENERAL.—A self-employed individual who is eligible to participate in the program under this title, who does not reside in a State where a self-employed individual is eligible for coverage in the small group market, and who does not elect to enroll in coverage under such program in the first year in which the self-employed individual is eligible to so enroll, shall be subject to an additional premium for delayed enrollment.

''(2) AMOUNT.—The Administrator shall establish the amount of the additional premium under paragraph (1), which shall be the amount determined by the Administrator to be actuarially appropriate, to encourage enrollment, and to reduce adverse selection. The amount of the additional pre-

mium shall be calculated by the Administrator based on the number of years specified in paragraph (4).

''(3) PAYMENT.—A self-employed individual shall pay the additional premium under this subsection, if any, for a period of time equal to the number of years specified in paragraph (4). After the expiration of such period the additional premium for delayed enrollment shall be terminated.

''(4) YEARS.—The number of years specified in this paragraph is the number of years that the self-employed individual involved was eligible to participate in the program under this title but did not enroll in coverage under such program and did not otherwise have creditable coverage (as defined for purposes of section 2701(c)).

''(g) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—With respect to the enforcement of provisions in this title that supersede State law (as described in paragraph (2)), a State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the small group market or through the program under this title, comply with the requirements of this title with respect to such issuers.

''(2) PROVISIONS DESCRIBED.—The provisions described in this paragraph shall include the following:

''(A) Prohibitions on varying premium rates based on health-status related factors (subsections (d)(1)(A) and (B) of section 3007).

''(B) The implementation of rating requirements that shall apply to the program under this title beginning in calendar year 2013 (subsections (d)(2)(B) and (d)(3) of section 3007).

''(C) Benefit requirements for nationwide plans available in the program under this title (subsection (e)).

''(3) FAILURE TO IMPLEMENT OR ENFORCE PROVISIONS.—In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) described in paragraph (2) with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions).

''(4) SECRETARIAL ENFORCEMENT AUTHORITY.—The Secretary shall have the same authority in relation to the enforcement of the provisions of

this title with respect to issuers of health insurance coverage in a State as the Secretary has under section 2722(b)(2) in relation to the enforcement of the provisions of part A of title XXVII with respect to issuers of health insurance coverage in the small group market in the State.

''(h) STATE OPT OUT.—A State may prohibit small employers and self-employed individuals in the State from participating in the program under this title if the State—

''(1) defines its small group market to include groups of one (so that self-employed individuals are eligible for coverage in such market);

''(2) prohibits the use of health-status related factors and other factors described in subsection (d)(5)(A);

''(3) has in effect rating rules that—

''(A) in calendar years 2011 and 2012, comply with subsection (d)(5)(A); and

''(B) in calendar year 2013 and thereafter, comply with subsection (d)(2)(B) or (d)(3), whichever is in effect for such calendar year;

except that such rules may impose limits on rating variation in addition to those provided for in such subsection;

''(4) maintains a State-wide purchasing pool that provides purchasers in the small group market a choice of health benefit plans, with comparative information provided concerning such plans and the premiums charged for such plans made available through the Internet; and

''(5) enacts a law to request an opt out under this subsection.

''SEC. 3008. ENCOURAGING PARTICIPATION BY HEALTH INSURANCE ISSUERS THROUGH ADJUSTMENTS FOR RISK.

''(a) APPLICATION OF RISK CORRIDORS.—

''(1) IN GENERAL.—This section shall only apply to health insurance issuers with respect to health benefits plans offered under this Act during any of calendar years 2011 through 2013.

''(2) NOTIFICATION OF COSTS UNDER THE PLAN.—In the case of a health insurance issuer that offers a health benefits plan under this title in any of calendar years 2011 through 2013, the issuer shall notify the Administrator, before such date in the succeeding year as the Administrator 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 health insurance issuer under this title, 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 health insurance issuer 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 health insurance issuer with re-

spect 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 Administrator shall reimburse the issuer for such excess costs through payment to the issuer 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 health insurance issuer 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 Administrator shall reimburse the issuer for such excess costs through payment to the issuer 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 health insurance issuer 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 issuer shall be required to pay into a contingency reserve fund established and maintained by the Administrator, 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 health insurance issuer 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 issuer shall be required to pay into the contingency fund established under subparagraph (A), 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 an issuer under this title in any of calendar years 2011 through 2013, an amount equal to—

''(i) the total of the monthly premiums estimated by the health insurance issuer and accepted by the Administrator to be paid for enrollees in the plan under this title for the calendar year involved; reduced by

''(ii) the amount of administrative expenses that the issuer estimates, and the Administrator accepts, will be incurred by the issuer with respect to the plan for such calendar year.

''(B) SUBMISSION OF TARGET AMOUNT.—Not later than December 31, 2010, and each December 31 thereafter through calendar year 2012, an issuer shall submit to the Adminis-

trator a description of the target amount for such issuer with respect to health benefits plans provided by the issuer under this title.

''(c) DISCLOSURE OF INFORMATION.—

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

''(A) that a health insurance issuer offering a health benefits plan under this title shall provide the Administrator with such information as the Administrator 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 Administrator has the right to inspect and audit any books and records of the issuer that pertain to the information regarding costs provided to the Administrator under such subsections.

''(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this subsection may be used by the office designated under section 3002(a) and its employees and contractors only for the purposes of, and to the extent necessary in, carrying out this section.

"SEC. 3009. ADMINISTRATION THROUGH REGIONAL OR OTHER ADMINISTRATIVE ENTITIES.

''(a) IN GENERAL.—In order to provide for the administration of the benefits under this title with maximum efficiency and convenience for participating employers and health care providers and other individuals and entities providing services to such employers, the Administrator—

''(1) shall enter into contracts with eligible entities, to the extent appropriate, to perform, on a regional or other basis, activities to receive, disburse, and account for payments of premiums to participating employers by individuals, and for payments by participating employers and employees to health insurance issuers; and

''(2) may enter into contracts with eligible entities, to the extent appropriate, to perform, on a regional or other basis, one or more of the following:

''(A) Collect and maintain all information relating to individuals, families, and employers participating in the program under this title.

''(B) Serve as a channel of communication between health insurance issuers, participating employers, and individuals relating to the administration of this title.

''(C) Otherwise carry out such activities for the administration of this title, in such

manner, as may be provided for in the contract entered into under this section.

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

''(3) PUBLICATION OF STANDARDS AND CRITERIA.—If the Administrator enters into contracts under subsection (a), the Administrator 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 implementa-

tion. In establishing such standards and criteria, the Administrator 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 2 years, 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 Administrator may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the entity involved as the Administrator may provide in regulations) if the Administrator 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 title.

''(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 Administrator such timely information and reports as the Administrator determines appropriate;

''(3) an assurance that the entity will maintain such records and afford such access thereto as the Administrator 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 title;

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

''(5) an assurance that the entity does not have, and will continue to avoid, any conflicts of interest relative to any functions it will perform; and

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

''SEC. 3010. PUBLIC EDUCATION CAMPAIGN AND REPORT.

''(a) IN GENERAL.—In carrying out this title, the Administrator shall develop and implement an educational campaign with interagency participation (including at a minimum the Small Business Administration, the Department of Labor, and employees of the office established under section 3002 who oversee the provision of information through navigators) to provide information to employers and the general public concerning the health insurance

program developed under this title, including the contact information relating to an individual or individuals who will be available to resolve various types of problems with health insurance coverage provided under this title.

''(b) 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 2008 through 2010.

''(c) REPORTS TO CONGRESS.—Not later than 1 year and 2 years after the implementation of the campaign under subsection (a), the Administrator shall submit to the appropriate committees of Congress a report that describes the activities of the Administrator under subsection (a), including a determination by the Administrator of the percentage of employers with knowledge of the health benefits program under this title.

''SEC. 3011. APPROPRIATIONS.

''There are authorized to be appropriated to the Administrator such sums as may be necessary in each fiscal year for the development and administration of the program under this title.

''SEC. 3012. EFFECTIVE DATE.

''This title shall take effect on the date of enactment of this title.''.

SEC. 3. AMENDMENT TO ERISA.

Section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)) is amended by adding at the end the following:

''(C) Notwithstanding subparagraph (A), the provisions of subsections (d)(1)(B) and (g)(2)(A) of section 3007 of the Public Health Service Act (relating to the prohibition on health-status related rating and the Federal enforcement of such provisions) shall supercede any State law that conflicts with such provisions.''.

SEC. 4. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to credits) is amended by inserting after section 45N the following new section:

''SEC. 45O. SMALL BUSINESS EMPLOYEE HEALTH INSURANCE CREDIT.

''(a) DETERMINATION OF CREDIT.—In the case of a qualified small employer, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the credit amount described in subsection (b).

''(b) GENERAL CREDIT AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The credit amount described in this subsection is the product of—

''(A) the amount specified in paragraph (2),

''(B) the employer size factor specified in paragraph (3), and

''(C) the percentage of year factor specified in paragraph (4).

''(2) APPLICABLE AMOUNT.—For purposes of paragraph (1)—

''(A) IN GENERAL.—The applicable amount is equal to—

''(i) $1,000 for each employee of the employer who receives self-only health insurance coverage through the employer,

''(ii) $2,000 for each employee of the employer who receives family health insurance coverage through the employer, and

''(iii) $1,500 for each employee of the employer who receives health insurance coverage for two adults or one adult and one or more children through the employer.

''(B) BONUS FOR PAYMENT OF GREATER PERCENTAGE OF PREMIUMS.—The applicable amount otherwise specified in subparagraph (A)

shall be increased by $200 in the case of subparagraph (A)(i), $400 in the case of subparagraph (A)(ii), and $300 in the case of subparagraph (A)(iii), for each additional 10 percent of the qualified employee health insurance expenses exceeding 60 percent which are paid by the qualified small employer.

''(3) EMPLOYER SIZE FACTOR.—For purposes of paragraph (1), the employer size factor is the percentage determined in accordance with the following table:

''If the employer size is:	The percentage is:
10 or fewer full-time employees	100%
More than 10 but not more than 20 full-time employees	80%
More than 20 but not more than 30 full-time employees	60%
More than 30 but not more than 40 full-time employees	40%
More than 40 but not more than 50 full-time employees	20%
More than 50 full-time employees	0%

''(4) PERCENTAGE OF YEAR FACTOR.—For purposes of paragraph (1), the percentage of year factor is equal to the ratio of—

''(A) the number of months during the taxable year for which the employer paid or incurred qualified employee health insurance expenses, and

''(B) 12.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) QUALIFIED SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'qualified small employer' means any employer (as defined in section 3001(a)(4) of the Public Health Service Act) which—

''(i) either—

''(I) purchases health insurance coverage for its employees in a small group market in a State which meets the requirements under subparagraph (B), or

''(II) with respect to any taxable year beginning after 2010, is a participating employer (as defined in section 3001(a)(8) of such Act) in the program under title XXX of such Act,

''(ii) pays or incurs at least 60 percent of the qualified employee health insurance expenses of such employer or is self-employed, and

''(iii) employed an average of 50 or fewer full-time employees during the preceding taxable year or was a self-employed

individual with either not less than $5,000 in net earnings or not less than $15,000 in gross earnings from self-employment in the preceding taxable year.

''(B) STATE SMALL GROUP MARKET REQUIREMENTS.—A State meets the requirements of this subparagraph if—

''(i) during calendar years 2009 and 2010, the State—

''(I) defines its small group market to include groups of one (so that self-employed individuals are eligible for coverage in such market),

''(II) prohibits the use of health-status related factors and other factors described in section 3007(d)(5)(A) of such Act, and

''(III) has in effect rating rules that comply with section 3007(d)(5)(A) of such Act (except that such rules may impose limits on rating variation in addition to those provided for in such section),

''(ii) during calendar years 2011 and 2012, the State—

"(I) meets the requirements under clause (i), and

"(II) maintains a State-wide purchasing pool that provides purchasers in the small group market a choice of health benefit plans, with comparative information provided concerning such plans and the premiums charged for such plans made available through the Internet, and

"(iii) for calendar years after 2012, the State—

"(I) meets the requirements under clauses (i)(I), (i)(II), and (ii)(II), and

"(II) has in effect rating rules that comply with paragraph (2)(B) or (3) of section 3007(d) of such Act, whichever is in effect for such calendar year (except that such rules may impose limits on rating variation in addition to those provided for in such section).

"(2) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

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

''(i) provided to any employee (as defined in subsection 3001(a)(3) of such Act), or

''(ii) for the employer, in the case of a self-employed individual.

''(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) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to any period, an employee (as defined in section 3001(a)(3) of such Act) of an employer if the average number of hours worked by such employee in the preceding taxable year for such employer was at least 35 hours per week.

''(d) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—For each taxable year after 2009, the dollar amounts specified in subsections (b)(2)(A), (b)(2)(B), and (c)(1)(A)(iii) (after the application of this paragraph) shall be the amounts in effect in the preceding taxable year or, if greater, the product of—

''(A) the corresponding dollar amount specified in such subsection, and

''(B) the ratio of the index of wage inflation (as determined by the Bureau of Labor Statistics) for August of the preceding calendar year to such index of wage inflation for August of 2008.

''(2) ROUNDING.—If any amount determined under paragraph (1) is not a multiple of $100, such amount shall be rounded to the next lowest multiple of $100.

''(e) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this section—

''(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 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 preceding taxable year, the determination of whether such employer meets the requirements of this section shall be based on the average number of full-time employees that it is reasonably expected such employer will employ on business days in the employer's first full taxable year.

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

''(f) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year. If the amount determined under this subsection is less than zero, the taxpayer shall owe additional tax in such amount under this chapter.

''(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 chap-

ter shall be treated as a credit allowable under this subpart to such qualified small business.''.

(b) ADVANCE PAYMENTS OF CREDIT.—Chapter 77 of the Internal Revenue Code of 1986 is amended by inserting after section 7527 the following new section:

''SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS FOR QUALIFIED SMALL EMPLOYERS.

''(a) GENERAL RULE.—Not later than December 31, 2008, the Secretary shall establish a program for making monthly payments on behalf of qualified small employers to the program established under title XXX of the Public Health Service Act. The amount of the monthly payment for a qualified small employer shall be one twelfth of the amount of the credit for the tax year to which the qualified small employer is entitled under section 36. If a monthly payment is made by the Secretary for which the employer is not entitled to a corresponding credit, the employer shall owe additional tax in such amount under this chapter.

''(b) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term 'qualified small employer' has the meaning given such term in section 36(c)(1).''.

(c) CONFORMING AMENDMENTS.—

(1) The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Rev-

enue Code of 1986 is amended by adding at the end the following new items:

"Sec. 45O. Small business employee health insurance credit.".

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

"Sec. 7527A. Advance payment of credit for health insurance costs for qualified small employers.".

(d) DEDUCTIBILITY.—The payment of premiums by a participating employer under this Act shall be considered to be an ordinary and necessary expense in carrying on a trade or business for purposes of the Internal Revenue Code of 1986 and shall be deductible.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2008.

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