I

110TH CONGRESS
2D SESSION

H. R. 6582

To encourage the development of small business cooperatives for healthcare options to improve coverage for employees (CHOICE) including through a small business CHOICE tax credit.

IN THE HOUSE OF REPRESENTATIVES

JULY 23, 2008

Ms. VELÁZQUEZ (for herself and Mr. PITTS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, 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 encourage the development of small business cooperatives for healthcare options to improve coverage for employees (CHOICE) including through a small business CHOICE tax credit.

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

SECTION 1. SHORT TITLES; TABLE OF CONTENTS.

(a) SHORT TITLES.—This Act may be cited as the ''Small Business Cooperative for Healthcare Options to Improve Coverage for Employees (CHOICE) Act of 2008'' or as the ''Small Business CHOICE Act of 2008''.

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

TITLE I—FULLY FUNDED SMALL BUSINESS HEALTH INSURANCE COOPERATIVES

SEC. 101. DEFINITIONS.

For purposes of this title:

(1) FULLY FUNDED HEALTH INSURANCE.—The term ''fully funded health insurance'' means, with respect to a fully funded small business health insurance cooperative, insurance provided to assume and spread a portion, of the risk of insuring the health liability exposure of the members of such cooperative.

(2) FULLY FUNDED SMALL BUSINESS HEALTH INSURANCE COOPERATIVE.—The term ''Fully Funded Small Business Health Insurance cooperative'' means a bona fide association or financial coopera-

tive organization of persons with a common affiliation (such as employment, labor union membership, place of residence, industry, or line of business) that form a captive insurance company chartered in a State that has adopted laws and regulations for captive insurers that are materially identical to standards to be developed by the National Association of Insurance Commissioners by July 1, 2009, if each of the following conditions are met:

(A) The cooperative—

(i) has no fewer than 100 members and no fewer than 5,000 lives (or, beginning as of 5 years after the date of the enactment of this Act, 15,000 lives); or

(ii) meets such minimum capital requirements as the Secretary shall specify, taking into account recommendations of the commission established under section 102.

(B) The cooperative administers the activities described in paragraph (1) separately from other activities of the cooperative.

(C) The cooperative is chartered or licensed as a captive insurance company under the laws of a State and is authorized to engage

in the business of insurance under the laws of such State.

(D) The cooperative does not vary the premium paid for a small business participating in the cooperative based on the health status of individuals for whom such small business purchases health insurance, or the claims experience of such small business and does not exclude such an individual from coverage based on the health status or claims experience of such individual.

(E) The cooperative has as its owners only small businesses—

(i) that comprise the membership of the cooperative; and

(ii) that are provided excess claims coverage insurance by the cooperative.

(F) Ownership, with respect to a member, is shared equitably among all participants in the cooperative.

(G) Each owner of a small business participating in the cooperative contracts with a primary insurer to provide fully insured employee health insurance.

(H) The cooperative provides excess claims coverage insurance that does not pay benefits in a year for an insured person until the annual maximum of the policy purchased from the insurer has been exceeded. The annual maximum of the primary insurance policy shall not be less than $10,000, and not be more than $250,000, per insured person in paid claims. The Secretary shall provide for an annual increase in the dollar amounts specified in the previous sentence based on annual inflation in health care expenses per capita for such persons.

(I) Benefits provided by excess claims coverage insurers must meet the high deductible health plan requirements of section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for a high deductible health plan provided under applicable State law.

(J) The excess claims coverage insurance offered by the cooperative meets all requirements of State law for the State in which it is offered.

(K) The name of the cooperative includes the phrase ''Fully Funded Small Business Health Insurance cooperative''.

Nothing in this paragraph shall be construed as preventing such a cooperative from requiring a small business, as a condition of becoming a member of the cooperative, to have a written commitment to the cooperative for such membership for a period of time.

(3) SMALL BUSINESS.—The term ''small business'' means a business that—

(A) has been classified as a small business concern by the Small Business Administration for purposes of the Small Business Act (15 U.S.C. 631 et seq.) under size standards established under section 3 of such Act (15 U.S.C. 632); or

(B) has no more than 500 employees, as calculated under section 121.106 of title 13, Code of Federal Regulations, as in effect as of January 1, 2007.

(4) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, and Puerto Rico.

SEC. 102. COMMISSION TO PROMOTE FULLY FUNDED SMALL BUSINESS HEALTH INSURANCE CO-OPERATIVES.

(a) ESTABLISHMENT.—Not later than January 1, 2009, the Secretary of the Treasury, in consultation with the Administrator of the Small Business Administration, shall establish, and provide for the operation of, an independent commission (in this section referred to as the ''commission'') on Fully Funded Small Business Health Insurance Cooperatives consistent with this section.

(b) COMPOSITION.—

(1) IN GENERAL.—Subject to subparagraph (B), the commission shall be comprised of one representative from each of the following organizations, as nominated by the organization to the Secretary of the Treasury:

(A) The American Academy of Actuaries.

(B) The National Association of Insurance Commissioners.

(C) The Captive Insurance Companies Association.

(D) The Conference of Consulting Actuaries.

(E) The Society of Actuaries.

(F) The Actuarial Board for Counseling and Discipline.

(G) The Actuarial Standards Board.

(2) LIMITATION.—No individual who has a business relationship with an active Fully Funded Small Business Health Insurance cooperative or who is employed by any State, Federal, or local entity may serve as a member of the commission.

(3) COMPENSATION.—

(A) IN GENERAL.—The Secretary shall provide to members of the commission compensation in an annual amount that does not exceed the amount specified in subparagraph (B).

(B) LIMITATION.—The amount specified in this subparagraph is $50,000, or, for a year after 2009, the amount specified in this subparagraph for the previous year increased by the annual percentage increase in the consumer price index for all urban consumers for the previous year.

(c) FUNCTIONS.—The commission shall—

(1) promote the development of Fully Funded Small Business Health Insurance cooperatives;

(2) provide for technical assistance in such development;

(3) make recommendations to the Secretary regarding minimum capital requirements referred to in section 102(2)(A)(ii);

(4) conduct oversight of Fully Funded Small Business Health Insurance cooperatives; and

(5) make quarterly reports to Congress regarding the development, implementation, and maintenance of such cooperatives, including the appropriate number of businesses and lives that should be required under section 101(2)(A) and the maximum amount of excess claims coverage insurance that should be provided per covered person.

(d) COMMISSION STAFF.—The commission shall provide for such staff, including an executive director, as it determines necessary to carry out its functions.

(e) COMMISSION HEADQUARTERS.—The commission shall be domiciled within the District of Columbia.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for purposes of carrying out subsection (a) $4,000,000 for fiscal year 2009 and $2,000,000 for each of fiscal years 2010 through 2013.

(g) RELATION TO FACA.—The provisions of section 14 of the Federal Advisory Committee Act shall not apply to the commission.

SEC. 103. FULLY FUNDED SMALL BUSINESS HEALTH INSURANCE COOPERATIVES EXEMPTED FROM CERTAIN STATE LAWS.

(a) IN GENERAL.—Except as provided in this title, a Fully Funded Small Business Health Insurance cooperative is exempt from any State law, rule, regulation, or order to the extent that such law, rule, regulation, or order would—

(1) prohibit the establishment of a Fully Funded Small Business Health Insurance cooperative;

(2) impose any material requirements, procedures, or standards (other than solvency requirements) on a Fully Funded Small Business Health Insurance cooperative that are not generally applicable to other entities engaged in a substantially similar business;

(3) require that a Fully Funded Small Business Health Insurance cooperative must have a minimum number of members, common ownership or affiliation, or a certain legal structure;

(4) require that any excess claims coverage insurance policy issued to a Fully Funded Small Business Health Insurance cooperative or any members of the cooperative be countersigned by an insurance agent or broker residing in the State involved; or

(5) otherwise discriminate against a Fully Funded Small Business Health Insurance cooperative or any of its members.

(b) APPLICATION OF EXEMPTIONS.—The exemptions specified in subsection (a) apply to—

(1) excess claims coverage insurance provided to—

(A) a Fully Funded Small Business Health Insurance cooperative; or

(B) any small business who is a member of a Fully Funded Small Business Health Insurance cooperative; and

(2) the provision of—

(A) excess claims coverage insurance coverage;

(B) excess claims coverage insurance related services;

(C) health management services such as—

(i) third party administrators;

(ii) disease management;

(iii) managed care organizations; and

(iv) data warehousing services; or

(D) health information technology, including electronic health records;

to a Fully Funded Small Business Health Insurance cooperative or member of the cooperative.

(c) REQUIREMENT FOR STATE LICENSURE PERMITTED.—A State may require that a person acting, or offering to act, as an agent or broker for a Fully Funded Small Business Health Insurance cooperative obtain a license from that State, except that a State may not impose any qualification or requirement which prohibits a licensed resident or nonresident agent or broker from selling within the State.

(d) STATE AUTHORITY PRESERVED.—

(1) Nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a Fully Funded Small Business Health Insurance cooperative is not exempt under this section.

(2) Nothing in this section shall affect the authority of any State to bring an action in any Federal or State court.

(3) Nothing in this section shall affect any State law regarding prompt payment of benefits.

(e) REQUIREMENTS FOR FINANCIAL INFORMATION.—Financial information submitted to the State insurance commissioner by a Fully Funded Small Business

Health Insurance cooperative must be certified by an independent public accountant and must include a statement of opinion on loss and loss adjustment expense reserves made by a certified actuary.

(f) FIDUCIARY RESPONSIBILITY.—

(1) IN GENERAL.—Each fiduciary (as defined in paragraph (3)(A)) of a Fully Funded Small Business Health Insurance cooperative shall exercise fiduciary responsibility (as defined in paragraph (3)(B)) in relation to activities of the cooperative.

(2) STATE AND FEDERAL RIGHTS OF ACTION.—

(A) LIMITATIONS ON LIABILITY UNDER STATE OR FEDERAL LAW.—In the case of a bona fide association or financial cooperative organization of individuals with a common affiliation (such as employment, labor union membership, or place of residence) that forms a Fully Funded Small Business Health Insurance cooperative in accordance with this Act, such association or organization shall not be liable in any action under State or Federal law for the actions of such cooperative except insofar as the association or organization is acting as a fiduciary with respect to the cooperative.

(B) EXCLUSIVE FEDERAL REMEDY FOR FIDUCIARY BREACHES.—To the extent that such association or organization exercises control over such cooperative and has breached a fiduciary responsibility to its membership in the formation or operation of such cooperative, a member of the association or organization may seek a remedy for such breach only in Federal court.

(C) LIMITATION ON VICARIOUS LIABILITY.—A fiduciary shall not be vicariously liable for the actions (including a failure to act) of an agent of the fiduciary in the absence of—

(i) actual knowledge of the fiduciary; and

(ii) approval or acquiescence by the fiduciary in the action (or failure to act).

(3) DEFINITIONS.—For purposes of this subsection:

(A) FIDUCIARY.—The term ''fiduciary'', with respect to a Fully Funded Small Business Health Insurance cooperative—

(i) means an officer, agent, or employee of the cooperative; and

(ii) includes any other person acting in concert with any such officer, agent, or employee with respect to the cooperative, if such other person has actual notice of such order.

(B) FIDUCIARY RESPONSIBILITY.—The term ''fiduciary responsibility'' means, with respect to a fiduciary of a cooperative, acting prudently and solely in the interest of the cooperative participants, including in the case of actions with respect to the selection and monitoring of the cooperative's relationship with a primary insurer and reinsurer.

(g) EFFECTIVE DATE.—This section shall apply to Fully Funded Small Business Health Insurance cooperative on and after the date of the enactment of this Act.

SEC. 104. PRESERVATION OF STATE BENEFIT MANDATES.

Notwithstanding any other provision of this title a primary health insurer to which this title applies shall not be exempted from benefit mandates under State law.

SEC. 105. ACCESS TO CLAIMS REPORTING DATA.

(a) FEDERAL PREEMPTION.—No law, regulation, or administrative action of a State or political subdivision thereof, or any decision or order rendered by a court under State law, shall have any effect if such law, regulation,

or decision conflicts with, hinders, poses an obstacle to or frustrates the purposes of this section.

(b) REQUIREMENTS UPON RECEIPT AND REQUEST OF CLAIMS INFORMATION.—

(1) IN GENERAL.—Not later than the 30th day after the date a health insurance issuer (as defined in section 2791(b)(2) of the Public Health Service Act), contracted to provide fully funded health insurance to members of a Fully Funded Small Business Health Insurance cooperative (referred to in this section as a ''Cooperative''), receives a written request for a report of claim information from the fiduciary (as defined in section 103(f)(3)(A)) of the Cooperative, the health insurance issuer shall provide the report to such fiduciary in accordance with this subsection.

(2) LIMITATION ON OBLIGATION.—The health insurance issuer is not obligated to provide a report under this subsection—

(A) regarding a particular employer or group health plan more than twice in any 12-month period; or

(B) unless the request is made not later than the second anniversary of the date of ter-

mination of coverage under a group health plan issued by the health insurance issuer.

(3) FORM OF REPORT.—A health insurance issuer shall provide the report of claim information under paragraph (1) through one of the following methods:

(A) In written form.

(B) Through an electronic file transmitted by secure electronic mail or a file transfer protocol site.

(C) By making the required information available through a secure website or web portal accessible by the Cooperative fiduciary.

(4) GENERAL CONTENTS OF REPORT.—A report of claim information provided under paragraph (1) shall contain all information available to the health insurance issuer that is responsive to the request made under such paragraph, including, subject to paragraphs (6) through (8), protected health information, for the 36-month period preceding the date of the report, or for the entire period of coverage, whichever period is shorter.

(5) SPECIFIC CONTENTS.—Subject to paragraphs (6) through (8), a report under paragraph (1) shall include the following:

(A) Aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable.

(B) Total premium paid by month.

(C) Total number of covered employees on a monthly basis by coverage tier, including whether coverage was for—

(i) an employee only;

(ii) an employee with dependents only;

(iii) an employee with a spouse only; or

(iv) an employee with a spouse and dependents.

(D) The total dollar amount of claims pending as of the date of the report.

(E) A separate description and individual claims report for any individual whose total paid claims exceed $10,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual:

(i) A unique identifying number, characteristic, or code for the individual.

(ii) The amounts paid.

(iii) Dates of service.

(iv) Applicable procedure codes and diagnosis codes.

(F) A statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report for claims that are not part of the report described by subparagraphs (A) through (E).

(6) PROTECTED HEALTH INFORMATION.—A health insurance issuer may not disclose, in a report of claim information provided under this section, protected health information if the health insurance issuer is prohibited from disclosing such information under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191). To withhold information in accordance with this paragraph, the health insurance issuer shall—

(A) notify the requesting Cooperative fiduciary that information is being withheld; and

(B) provide to the Cooperative fiduciary a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under such regulations.

(7) COOPERATIVE FIDUCIARY CERTIFICATION.—A Cooperative fiduciary is entitled to receive protected health information under subparagraphs (E) and (F) of paragraph (5) only after the Cooperative fiduciary makes to the health insurance issuer a certification substantially similar to the following: ''I hereby certify that the Cooperative will safeguard and limit the use and disclosure of protected health information that is received from the group health plan to perform the plan administration functions.''.

(8) INFORMATION AS OF DATE OF TERMINATION OF COVERAGE.—In the case of a request made under paragraph (1) after the date of termination of coverage, the report shall contain all information available to the health insurance issuer as of the date of the report that is responsive to the request, including protected health information, and including the information described in subparagraphs (A) through (F) of paragraph (5) for the period described in such paragraph preceding the date of termination of coverage or for the entire policy period, whichever period is shorter. Notwithstanding this paragraph, such a report may not include the protected health information described in subpara-

graph (E) or (F) of paragraph (5) unless a certification has been provided in accordance with paragraph (7).

(c) REQUEST FOR ADDITIONAL INFORMATION.—

(1) IN GENERAL.—On receipt of a report required by subsection (b), the Cooperative fiduciary may review the report and, not later than the 10th day after the date the report is received, may make a written request to the health insurance issuer for additional information in accordance with this subsection for specified individuals.

(2) PROVISION OF ADDITIONAL INFORMATION.—With respect to a request for additional information under paragraph (1) concerning specified individuals for whom claims information has been provided under subsection (b)(5)(E), the health insurance issuer shall provide additional information on the prognosis or recovery if available and, for individuals in active case management, the most recent case management information, including any future expected costs and treatment plan, that relate to the claims for that individual.

(3) TIMELY RESPONSE.—The health insurance issuer shall respond to the request for additional information under this subsection not later than the

15th day after the date of receiving the request unless the Cooperative fiduciary agrees to a request for additional time.

(4) CERTIFICATION REQUIREMENT.—The health insurance issuer is not required to produce the report described by this subsection unless a certification has been provided in accordance with subsection (b)(7).

(d) LIMITATION ON LIABILITY FOR DISCLOSURE OF INFORMATION.—A health insurance issuer that releases information, including protected health information, in accordance with this section has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.

(e) PENALTIES.—A health insurance issuer that does not comply with a request for information in accordance with this section is subject to administrative penalties in an amount not to exceed $25,000 per affected individual.

TITLE II—SMALL BUSINESS CHOICE CREDIT

SEC. 201. SMALL BUSINESS CHOICE CREDIT.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of

1986 (relating to business related credits) is amended by adding at the end the following new section:

"SEC. 450. SMALL BUSINESS CHOICE CREDIT.

"(a) IN GENERAL.—For purposes of section 38, the small business CHOICE credit determined under this section for any taxable year is an amount equal to 65 percent of the amount paid or incurred by the employer for self only or family coverage of an employee under a qualified employer-subsidized health coverage for eligible coverage months beginning in the taxable year.

"(b) LIMITATIONS.—

"(1) SIZE LIMITATION.—The credit allowed under subsection (a) shall not be allowed with respect to more than 100 employees of the employer for any eligible coverage month beginning in any taxable year.

"(2) WELLNESS PROGRAM REQUIREMENT.—

"(A) IN GENERAL.—The credit allowed under subsection (a) shall not be allowed with respect to coverage of an employee and family members of the employee unless the employer offers a qualified small business wellness program with respect to such covered employees and such covered family members.

''(B) EXEMPTION FOR SINGLE EMPLOYEE FIRMS.—Subparagraph (A) shall not apply to an employer that has only 1 employee.

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

''(1) ELIGIBLE COVERAGE MONTH.—The term 'eligible coverage month' means any month if—

''(A) as of the first day of such month, the employer is a member of a Fully Funded Small Business Health Insurance cooperative and purchases excess coverage from such cooperative's captive insurance company; and

''(B) for the month the employee with respect to whom the credit is determined is covered under a qualified employer-subsidized health coverage of the employer.

''(2) FULLY FUNDED SMALL BUSINESS HEALTH INSURANCE COOPERATIVE.—The term 'Fully Funded Small Business Health Insurance cooperative' has the meaning given such term in section 101(2) of the Small Business CHOICE Act of 2008.

''(3) QUALIFIED EMPLOYER-SUBSIDIZED HEALTH COVERAGE.—

''(A) IN GENERAL.—The term 'qualified employer-subsidized health coverage' means any

insurance coverage which constitutes medical care under an insurance policy—

''(i) which is maintained in conjunction with excess coverage purchased from a fully funded small business captive company and coverage purchased from a licensed primary insurer;

''(ii) which is available to all full-time employees working a minimum of 35 hours per week or its monthly equivalent;

''(iii) under which at least the applicable percentage of the cost of such coverage (determined under section 4980B) is paid or incurred by the employer;

''(iv) under which the percentage of the cost of such coverage paid or incurred by the employer with respect to highly compensated employees (as defined in section 414(q)) does not exceed the percentage of such cost paid or incurred by the employer with respect to employees who are not highly compensated employees; and

''(v) the primary insurance and excess claims coverage plans are the only plans of

the employer to which the employer contributes to the cost of coverage.

''(B) EXCEPTION FOR CERTAIN COVERAGE.—Such term does not include a health plan substantially all of the coverage of which is of excepted benefits described in section 9832(c).

''(C) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage is—

''(i) 65 percent, with respect to self only coverage; and

''(ii) 35 percent, with respect to family coverage.

''(4) QUALIFIED SMALL BUSINESS WELLNESS PROGRAM.—The term 'qualified small business wellness program' means a program which—

''(A) is established by an entity with expertise in lifestyle management and wellness tools that enable employers and covered individuals to lower health claims and costs while improving the health of such individuals; and

''(B) is certified by the Secretary of Health and Human Services, in consultation with persons with expertise in employer health pro-

motion and wellness programs, as a qualified small business wellness program under this section.

''(5) SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'small employer' means, with respect to a taxable year, any employer or sole proprietor which employed an average of 100 or fewer employees on business days during the preceding calendar year. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer or sole proprietor was in existence throughout such year.

''(B) EMPLOYERS AND SOLE PROPRIETORS NOT IN EXISTENCE IN PRECEDING TAXABLE YEAR.—In the case of an employer or sole proprietor which was not in existence throughout the preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer or sole proprietor will employ on business days in the current calendar year.

''(6) SPECIAL RULE FOR FIRST YEAR OF PROVIDING HEALTH BENEFITS COVERAGE.—In the case

of the first taxable year for which an employer or sole proprietor is allowed a credit under this section, if the employer or proprietor has not previous to such taxable year offered any health benefits coverage to any employee, subsection (a) shall be applied by substituting '70 percent' for '65 percent'.

''(7) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A rule similar to the rule of section 219(f)(3) shall apply for purposes of this section.

''(8) CONTROLLED GROUPS AND PREDECESSORS.—For purposes of paragraphs (5) and (6)—

''(A) except as provided by the Secretary, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer; and

''(B) any reference to an employer shall include a reference to any predecessor of such employer.

''(9) ELECTION TO HAVE CREDIT APPLY.—This section shall apply with respect to a taxpayer for any taxable year only if there is an election in effect by such taxpayer (at such time and in such manner as the Secretary may by regulations prescribe) to have this section apply for such taxable year. No deduc-

tion shall be allowed with respect to amounts paid by the taxpayer during the taxable year for insurance which constitutes medical care for the taxpayer or any employee of the taxpayer if such election is in effect for such taxable year.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking ''plus'' at the end of paragraph (30), by striking the period at the end of paragraph (31) and inserting ''plus'', and by adding at the end the following new paragraph:

''(32) the Small Business CHOICE credit determined under section 45O(a).''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding at the end the following new item:

''Sec. 45O. Small Business CHOICE credit.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid for eligible coverage months beginning in taxable years beginning after December 31, 2008.

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