

110TH CONGRESS
1ST SESSION

S. 3554

To provide employees of small employers with access to quality, affordable health insurance coverage.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 24 (legislative day, SEPTEMBER 17), 2008

Mr. SMITH (for himself and Mr. LIEBERMAN) introduced the following bill;
which was read twice and referred to the Committee on Finance

A BILL

To provide employees of small employers with access to quality, affordable health insurance coverage.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Affordable Coverage for Small Employers Act of 2008”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Definitions.
- Sec. 4. National Health Coverage Policy Board.
- Sec. 5. Health Coverage Exchange Regions.
- Sec. 6. Regional Health Coverage Exchanges.
- Sec. 7. Health plan offered through an Exchange.

Sec. 8. Refundable credit for health insurance coverage.

Sec. 9. Refundable credit for small employer health insurance expenses.

Sec. 10. Reports and evaluations.

Sec. 11. Reporting insurance status.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) Forty-seven million Americans lack con-
4 sistent access to quality, affordable health coverage.

5 The chronic problem of the uninsured ranks as one
6 of the Nation's most pressing health care challenges.

7 (2) More than half of uninsured Americans are
8 employed by small businesses, or firms with fewer
9 than 100 employees.

10 (3) Research shows that affordability is a key
11 barrier to small businesses purchasing coverage in
12 the private market. Sixty-three percent of uninsured
13 businesses cite affordability as a major reason that
14 they do not offer health benefits to their employees.

15 (4) Surveys also indicate that 71 percent of
16 small employers would offer their employees health
17 benefits if the government provided assistance with
18 premiums.

19 (5) Offering health benefits is not only good for
20 employees' health, it is good for the health of busi-
21 nesses. Small employers report access to affordable
22 health insurance coverage as a key factor in their
23 economic performance. Of those small employers

1 who do offer health benefits to their employees, 64
2 percent believe it increases productivity by keeping
3 employees healthy and 58 percent claim it reduces
4 absenteeism.

5 (6) While there may be varying ideas on how
6 best to provide affordable coverage to small employ-
7 ers, one thing is clear: the solution lies in a coopera-
8 tive effort between individuals, employers, and Fed-
9 eral and State governments.

10 (7) As part of reforming the Nation’s health
11 care system, Congress should make it a priority to
12 reduce the number of uninsured by helping small
13 businesses purchase affordable coverage for their
14 employees.

15 **SEC. 3. DEFINITIONS.**

16 In this Act:

17 (1) EMPLOYER.—The term “employer” has the
18 meaning given such term under section 3(5) of the
19 Employee Retirement Income Security Act of 1974.

20 (2) EXCHANGE.—The term “Exchange” means
21 a Regional Health Coverage Exchange established
22 under section 6.

23 (3) NATIONAL POLICY BOARD.—The term “Na-
24 tional Policy Board” means the National Health
25 Coverage Policy Board established under section 4.

1 (4) REGION.—The term “Region” means a
2 Health Coverage Exchange Region established under
3 section 5.

4 (5) REGIONAL BOARDS.—The term “Regional
5 Boards” means the board of a Regional Health Cov-
6 erage Exchange established under section 6.

7 (6) SECRETARY.—The term “Secretary” means
8 the Secretary of Health and Human Services.

9 (7) SMALL EMPLOYER.—

10 (A) IN GENERAL.—The term “small em-
11 ployer” means, with respect to a plan year, an
12 employer who employed an average of at least
13 2 but not more than 100 full-time employees on
14 business days during the preceding calendar
15 year and who employs at least 2 employees on
16 the first day of the plan year. Such term may
17 include a sole proprietor if determined appro-
18 priate by a Regional Board.

19 (B) APPLICATION OF CERTAIN RULES IN
20 DETERMINATION OF EMPLOYER SIZE.—For
21 purposes of this paragraph—

22 (i) APPLICATION OF AGGREGATION
23 RULE FOR EMPLOYERS.—All persons treat-
24 ed as a single employer under subsection
25 (b), (c), (m), or (o) of section 414 of the

1 Internal Revenue Code of 1986 shall be
2 treated as 1 employer.

3 (ii) EMPLOYERS NOT IN EXISTENCE
4 IN PRECEDING YEAR.—In the case of an
5 employer which was not in existence
6 throughout the preceding calendar year,
7 the determination of whether such em-
8 ployer is a small or large employer shall be
9 based on the average number of employees
10 that it is reasonably expected such em-
11 ployer will employ on business days in the
12 current calendar year.

13 (iii) PREDECESSORS.—Any reference
14 in this subsection to an employer shall in-
15 clude a reference to any predecessor of
16 such employer.

17 (8) SOLE PROPRIETOR.—The term “sole propri-
18 etor” means a business structure in which an indi-
19 vidual and his or her company are considered a sin-
20 gular entity for Federal tax and liability purposes, and
21 he or she reports business income or losses on his
22 or her individual income tax return.

23 (9) STATE.—The term “State” means each of
24 the several States of the United States, the District
25 of Columbia, and any territory sufficiently regu-

1 lating its insurance market as determined by the
2 National Association of Insurance Commissioners.

3 **SEC. 4. NATIONAL HEALTH COVERAGE POLICY BOARD.**

4 (a) ESTABLISHMENT.—

5 (1) IN GENERAL.—There shall be established as
6 an independent agency a National Health Coverage
7 Policy Board that shall be composed of 9 members,
8 to be appointed by the President not later than 12
9 months after the date of enactment of this Act, by
10 and with the advice and consent of the Senate, for
11 terms of 6 years, except that the terms of the initial
12 members of the National Policy Board shall be stag-
13 gered. Upon the expiration of their terms of office,
14 members of the National Policy Board shall continue
15 to serve until their successors are appointed and
16 have qualified.

17 (2) REQUIREMENT OF EXPERTISE.—In select-
18 ing the members of the National Policy Board, the
19 President shall ensure that such membership include
20 representatives of insurance commissioners, insur-
21 ance issuers and producers, health care providers,
22 small employers, health plan accreditors, actuaries,
23 health care quality experts, and consumers, and that
24 such members provide geographical diversity.

1 (3) EX OFFICIO MEMBERS.—The Secretary of
2 Health and Human Services and the Secretary of
3 the Treasury, or their designees, shall serve as ex
4 officio members of the National Health Coverage
5 Policy Board.

6 (4) COMPENSATION.—A member of the Na-
7 tional Policy Board shall be entitled to compensation
8 at the per diem equivalent of the rate provided for
9 level IV of the Executive Schedule under section
10 5315 of title 5, United States Code, and while so
11 serving away from home and the member's regular
12 place of business, a member may be allowed travel
13 expenses, as authorized by the Chairperson of the
14 National Policy Board.

15 (b) DUTIES.—The National Policy Board shall—

16 (1) apportion the United States into Health
17 Coverage Exchange Regions, pursuant to section 5;

18 (2) provide for the establishment, and oversee
19 the administration of Regional Health Coverage Ex-
20 changes pursuant to section 6;

21 (3) establish and appoint members to the Re-
22 gional Health Coverage Exchange Board for each of
23 the Regions established under section 6;

1 (4) determine a comprehensive, quality, and af-
2 fordable standard benefit package and cost sharing
3 requirements in accordance with subsection (c);

4 (5) develop and recommend maximum rating
5 guidelines for each Exchange, which shall take into
6 consideration existing requirements in each State in
7 the Region;

8 (6) establish and update regularly the quality
9 and efficiency performance and reporting require-
10 ments for health plans offered through an Exchange;

11 (7) provide technical assistance to Regional
12 Boards as necessary;

13 (8) submit an annual report to Congress con-
14 cerning the activities of the National Policy Board;
15 and

16 (9) carry out any other activities determined
17 appropriate by the Secretary.

18 (c) STANDARD BENEFIT PACKAGE.—

19 (1) IN GENERAL.—The standard benefit pack-
20 age developed under subsection (b)(4) shall, at a
21 minimum, include coverage for—

22 (A) preventive items and services (includ-
23 ing well baby care, well child care, and appro-
24 priate immunizations), as recommended by the
25 United States Preventive Services Task Force;

1 (B) chronic disease care services, which
2 may include disease management, care coordi-
3 nation, and case management programs;

4 (C) inpatient and outpatient hospital serv-
5 ices (including mental health care and mater-
6 nity care);

7 (D) physicians' surgical and medical serv-
8 ices;

9 (E) laboratory and imaging services; and

10 (F) dental and prescription drug coverage.

11 (2) INITIAL PACKAGE.—The initial standard
12 benefit package developed by the National Policy
13 Board under subsection (b)(4) shall have benefits
14 that are similar to or not less than the actuarial
15 value of health benefits coverage in any of the 4
16 largest health benefits plans (determined by enroll-
17 ment) offered under the Federal Employee Health
18 Benefit Program under chapter 89 of title 5, United
19 States Code. Such benefit package shall remain in
20 effect for a 2-year period.

21 (3) REVISIONS.—Not later than 2 years after
22 the development of the standard benefit package
23 under subsection (b)(4), and annually thereafter, the
24 National Policy Board, in consultation with the In-
25 stitute of Medicine, shall review and make revisions

1 to such benefit package to ensure that coverage is
2 provided for all medically reasonable and necessary
3 items and services. Such revisions shall be made in
4 accordance with available clinical practice guidelines
5 and advances in medical science which have been
6 demonstrated to meaningfully improve health out-
7 comes.

8 (d) ANNUAL AUDITS.—The National Policy Board
9 shall submit to Secretary and the appropriate committees
10 of Congress an annual financial audit of the activities of
11 the National Policy Board, to be conducted by an inde-
12 pendent party.

13 (e) ADMINISTRATIVE PROVISIONS.—

14 (1) CHAIRPERSON.—Of the individuals ap-
15 pointed to the National Policy Board under sub-
16 section (a)(1), one member shall be designated by
17 the President, by and with the advice and consent
18 of the Senate, to serve as the Chairperson of the Na-
19 tional Policy Board for a term of 6 years, and one
20 shall be designated by the President, by and with
21 the consent of the Senate, to serve as Vice Chair-
22 person of the National Policy Board for a term of
23 4 years. The Chairperson of the National Policy
24 Board, subject to its supervision, shall be its active
25 executive officer.

1 (2) QUORUM; APPROVAL.—

2 (A) QUORUM.—A majority of the members
3 of the National Policy Board shall constitute a
4 quorum, but a lesser number of members may
5 hold hearings.

6 (B) APPROVAL.—An affirmative vote of a
7 majority of the members of the National Policy
8 Board is required for approval of all National
9 Policy Board decisions.

10 (3) MEETINGS.—

11 (A) IN GENERAL.—The National Policy
12 Board shall meet at the call of the Chairperson.
13 At meetings of the National Policy Board the
14 Chairperson shall preside, and, in his or her ab-
15 sence, the vice chairperson shall preside. In the
16 absence of the Chairperson and the vice chair-
17 person, the National Policy Board shall elect a
18 member to act as chairperson pro tempore.

19 (B) REGIONAL BOARD MEETINGS.—In ad-
20 dition to other meetings the National Policy
21 Board may hold, the National Policy Board
22 shall hold an annual meeting with the Regional
23 Boards, for the purpose of having Regional
24 Boards report progress towards expanding ac-

1 cess to health coverage for employees of small
2 businesses and for an exchange of information.

3 (4) HEARINGS.—The National Policy Board
4 may hold such hearings, sit and act at such times
5 and places, take such testimony, and receive such
6 evidence as the National Policy Board considers ad-
7 visable to carry out the purposes of this section.

8 (5) INFORMATION.—The National Policy Board
9 may secure directly from any Federal department or
10 agency such information as the National Policy
11 Board considers necessary to carry out the provi-
12 sions of this section. Upon request of the Chair-
13 person of the National Policy Board, the head of
14 such department of agency shall furnish such infor-
15 mation to the National Policy Board if the head of
16 such department or agency determines it appro-
17 priate.

18 (6) POSTAL SERVICES.—The National Policy
19 Board may use the United States mails in the same
20 manner and under the same conditions as other de-
21 partments and agencies of the Federal Government.

22 (7) TRAVEL EXPENSES.—The members of the
23 National Policy Board shall be allowed travel ex-
24 penses, including per diem in lieu of subsistence, at
25 rates authorized for employees of agencies under

1 subchapter I of chapter 57 of title 5, United States
2 Code, while away from their homes or regular places
3 of business in the performance of services for the
4 National Policy Board.

5 (8) OFFICES.—The principal offices of the Na-
6 tional Policy Board shall be in the District of Co-
7 lumbia.

8 (9) EXPERTS AND EMPLOYEES.—The National
9 Policy Board shall have the power to employ such
10 attorneys, experts, assistants, clerks, or other em-
11 ployees as may be deemed necessary to conduct the
12 business of the National Policy Board. All salaries
13 and fees shall be fixed in advance by the National
14 Policy Board and shall be paid in the same manner
15 as the salaries of the members of the National Pol-
16 icy Board.

17 (10) ENFORCEMENT.—The National Policy
18 Board may act in its own name and through its own
19 attorneys in enforcing any provision of this Act, reg-
20 ulations promulgated hereunder, or any other law or
21 regulation, or in any action, suit, or proceeding to
22 which the National Policy Board is a party.

23 (11) DETAIL OF GOVERNMENT EMPLOYEES.—
24 Any Federal Government employee may be detailed
25 to the National Policy Board without reimburse-

1 ment, and such detail shall be without interruption
2 or loss of civil service status or privilege.

3 (12) TEMPORARY AND INTERMITTENT SERV-
4 ICES.—The Chairperson of the National Policy
5 Board may procure temporary and intermittent serv-
6 ices under section 3109(b) of title 5, United States
7 Code, at rates for individuals which do not exceed
8 the daily equivalent of the annual rate of basic pay
9 prescribed for level V of the Executive Schedule
10 under section 5316 of such title.

11 (13) ANNUAL REQUEST FOR FUNDING.—The
12 National Policy Board shall submit an annual re-
13 quest to the Secretary for funding to carry out this
14 section.

15 (14) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated for each fis-
17 cal year, such sums as may be necessary to maintain
18 the functions of the National Policy Board.

19 **SEC. 5. HEALTH COVERAGE EXCHANGE REGIONS.**

20 (a) IN GENERAL.—The National Policy Board shall
21 divide the United States into Health Coverage Exchange
22 Regions. Such Regions may be reapportioned and new Re-
23 gions may from time to time be established by the Na-
24 tional Policy Board. No Region may contain less than 2
25 States.

1 (b) APPORTIONMENT.—

2 (1) IN GENERAL.—In establishing Regions
3 under subsection (a), the National Policy Board
4 shall ensure that such Regions are apportioned with
5 due regard to the convenience and customary course
6 of business, including existing State insurance rating
7 guidelines and regulations.

8 (2) CONSIDERATIONS.—Regions under this sec-
9 tion need not consist of coterminous States. In de-
10 termining whether a Region will consist of States
11 that are not coterminous, the National Policy Board
12 shall consider the market availability of health plans
13 and whether plans in the Region can comply with
14 State network adequacy requirements.

15 (3) APPEALS.—A State may submit an appeal
16 to the National Policy Board if the State desires to
17 be assigned to another Health Coverage Exchange
18 Region. In such an appeal, a State shall provide rea-
19 sonable justification that the convenience and cus-
20 tomary course of business of the State, including ex-
21 isting State insurance rating guidelines and regula-
22 tions, are more similar to a Region other than the
23 Region to which the State was initially assigned by
24 the National Policy Board.

1 (c) EXCHANGES.—Within each Region, the National
 2 Policy Board shall establish a health coverage exchange
 3 as provided for under section 6.

4 **SEC. 6. REGIONAL HEALTH COVERAGE EXCHANGES.**

5 (a) REGIONAL HEALTH CARE EXCHANGES.—The
 6 Board shall establish Regional Health Coverage Ex-
 7 changes to serve as central purchasing sites for health cov-
 8 erage, to provide information to purchasers and consumers
 9 about participating health plans, to facilitate enrollment,
 10 and to ensure health plan compliance with minimum re-
 11 quirements for benefit design, quality, efficiency and
 12 transparency.

13 (b) ESTABLISHMENT AND APPOINTMENT.—

14 (1) IN GENERAL.—The National Policy Board
 15 shall establish and appoint the members of a Re-
 16 gional Health Coverage Exchange Board for each
 17 Region. The National Policy Board shall—

18 (A) determine the number of members of
 19 each Regional Board which shall be dependent
 20 upon the size of the Region involved; and

21 (B) establish a process whereby State offi-
 22 cials and other stakeholders submit nominations
 23 for appointment to each Regional Board.

24 (2) REQUIREMENTS.—At a minimum the mem-
 25 bership of each Regional Board shall include the

1 State insurance commissioner from each State in the
2 Region involved and other members who shall be
3 representative of health insurance issuers and pro-
4 ducers, health care providers, health plan
5 accreditors, small employers, health care quality ex-
6 perts, and consumers.

7 (3) TERMS.—In appointing members of a Re-
8 gional Board, the National Policy Board shall ensure
9 that the terms of service for such members are stag-
10 gered and that no term exceeds 6 years.

11 (c) DUTIES.—The Regional Board, shall—

12 (1) develop common rating guidelines relating
13 to the health insurance market for small employers,
14 pursuant to subsection (d);

15 (2) establish and administer the Exchange to
16 assist small employers within the Region with pur-
17 chasing health coverage for themselves and their em-
18 ployees, as described in subsection (d);

19 (3) provide assistance to States within the Re-
20 gion concerning health plan quality and efficiency
21 compliance and enforcement;

22 (4) consult with the National Association of In-
23 surance Commissioners and develop a mechanism to
24 lessen such risk selection as may occur among plans
25 participating in the Exchange through the applica-

1 tion of regional risk adjustment requirements that
 2 are submitted to and approved by the National Pol-
 3 icy Board;

4 (5) collect data for evaluation, and for reporting
 5 to the public and the National Policy Board, con-
 6 cerning the overall effectiveness of the Exchange,
 7 which may include number of enrollees, types of ben-
 8 efit options offered by health insurance issuers, the
 9 rating guidelines implemented, marketing practices,
 10 quality oversight, and any enforcement procedures
 11 applied;

12 (6) submit annual reports to the National Pol-
 13 icy Board concerning the activities and evaluation of
 14 the Exchange; and

15 (7) carry out other activities determined appro-
 16 priate by the National Policy Board.

17 (d) COMMON REGULATORY GUIDELINES; STATE

18 ADOPTION.—

19 (1) COMMON REGULATORY GUIDELINES.—

20 (A) IN GENERAL.—Not later than 6
 21 months after the date on which the members of
 22 the Regional Board are appointed, such Re-
 23 gional Board shall develop and submit common
 24 rating guidelines to the National Policy Board
 25 for review and approval.

1 (B) APPROVAL.—The National Policy
2 Board shall notify the Regional Board of its de-
3 cision with respect to common rating guidelines
4 within 60 days of the receipt of the submission
5 of such guidelines under subparagraph (A). If
6 the National Policy Board does not approve
7 such guidelines, the National Policy Board shall
8 provide the Regional Board with a justification
9 for such decision. The Regional Board may re-
10 submit modified common rating guidelines for
11 approval within the 30-day period beginning on
12 that date of such notification of the National
13 Policy Board’s initial decision.

14 (C) LIMITATION.—The common guidelines
15 under this paragraph may not include—

16 (i) health status as an allowable rat-
17 ing factor; or

18 (ii) waiting periods or exclusion of
19 coverage for pre-existing conditions.

20 (D) MODIFICATIONS.—A Regional Board
21 that desires to modify the common rating
22 guidelines approved by the National Policy
23 Board under subparagraph (A) shall submit a
24 report to the National Policy Board that de-
25 scribes the proposed modification and how such

1 modification will affect consumer access to af-
2 fordable health coverage for review and ap-
3 proval. The National Policy Board shall notify
4 the Regional Board of its decision with respect
5 to such modification within 60 days of receipt
6 of the modification request. Approval of such
7 proposed modifications shall be contingent upon
8 assurances that access to health coverage for
9 small employers and their employees would be
10 maintained.

11 (E) FAILURE TO DEVELOP.—If the Re-
12 gional Board is unable to develop common rat-
13 ing guidelines within the period provided for
14 under subparagraph (A), the National Policy
15 Board may develop such guidelines to be ap-
16 plied by the Regional Board or reapportion the
17 States within the Region involved to other Re-
18 gions.

19 (2) STATE ADOPTION.—

20 (A) IN GENERAL.—Not later than 3 years
21 after the date on which the Regional Board is
22 appointed, each State in the Region involved
23 shall enact the laws necessary to regulate its
24 small group insurance market in accordance
25 with the guidelines developed by the Regional

1 Board under paragraph (1). The National Pol-
2 icy Board may permit a State to phase-in the
3 enactment of the guidelines developed under
4 paragraph (1) over a period not to exceed 3
5 years.

6 (B) FAILURE TO ENACT.—If a State fails
7 to enact and implement the guidelines devel-
8 oped under paragraph (1) within the period
9 provided for under subparagraph (A), the small
10 employers in such State—

11 (i) shall not be permitted to purchase
12 health coverage through the Exchange; and

13 (ii) shall not be eligible for the refund-
14 able income tax credit under section 36A
15 of the Internal Revenue Code of 1986.

16 (C) CERTAIN STATES.—States that have
17 legislatures meeting biennially and that make a
18 good faith effort to implement the rating guide-
19 lines for its Region may have the penalties de-
20 scribed in subparagraph (B) waived at the dis-
21 cretion of the National Policy Board. If a State
22 fails to fully implement the Region’s common
23 guidelines by the date that is 1 year after the
24 end of its next legislative session, the National
25 Policy Board shall enforce the penalties de-

1 scribed in such subparagraph with respect to
2 such State.

3 (D) DETERMINATION BY REGIONS WITH
4 RESPECT TO COVERAGE OF ADDITIONAL POPU-
5 LATIONS.—A Regional Board shall permit sole
6 proprietors and individuals to purchase cov-
7 erage through the Exchange if the State in-
8 volved elects to permit such coverage. A State
9 within a Region that permits sole proprietors or
10 individuals to purchase coverage through the
11 Exchange shall regulate the individual health
12 insurance markets within the State in accord-
13 ance with the common rating guidelines pro-
14 vided for in this subsection. To mitigate the
15 risk of adverse selection within such markets,
16 the Regional Board may exercise additional
17 flexibility by taking group size into account
18 when developing common rating guidelines.

19 (E) DETERMINATION BY STATES WITH RE-
20 SPECT TO EXCEEDING SMALL EMPLOYER SIZE
21 LIMITS.—States may request that the definition
22 of “small employer” be expanded to include
23 those small employers with more than 100 em-
24 ployees. Such request shall be made in writing
25 and approved by the National Policy Board.

1 The National Policy Board shall take into con-
2 sideration the availability of refundable income
3 tax credits under section 36A of the Internal
4 Revenue Code of 1986, as well as potential im-
5 pact on access to health coverage for other
6 small employers. The National Policy Board
7 shall act upon a request made under this sec-
8 tion not later than 60 days after receipt of such
9 request.

10 (F) CROWD-OUT REDUCTION.—Each Re-
11 gional Board shall develop a plan to decrease
12 adverse selection relating to health insurance
13 coverage between the individual market and the
14 Exchange for individuals and sole proprietors
15 eligible to purchase coverage through the
16 Health Coverage Exchange. Such plan shall be
17 submitted to the National Policy Board for ap-
18 proval in conjunction with the submission of
19 common rating guidelines described in this sub-
20 section.

21 (G) STATE OPT OUT.—A State may submit
22 a request to the National Policy Board to opt
23 out of the requirement relating to the adoption
24 of the common guidelines under section 6 if the
25 State can demonstrate that existing State

1 guidelines are more stringent than those rec-
2 ommended by the Regional Board under such
3 section.

4 (e) ESTABLISHMENT AND ADMINISTRATION OF EX-
5 CHANGE.—A Regional Board shall establish and admin-
6 ister an Exchange through the following activities:

7 (1) The development of streamlined health in-
8 surance marketing and enrollment mechanisms,
9 through collaboration with insurance producers,
10 which shall include the establishment and mainte-
11 nance of an Internet website.

12 (2) The development of contracting processes
13 and the conduct of negotiations with insurance
14 issuers that desire to participate in the Exchange.

15 (3)(A) Collaboration with participating health
16 insurance issuers and producers to develop health
17 coverage benefit packages to be offered through the
18 Exchange in addition to the standard benefit pack-
19 age provided for in section 4.

20 (B) If such standard benefit package does not
21 include all mandated benefits for each State in the
22 Region, the Regional Board may require that health
23 plans participating in the Exchange offer additional,
24 modified plans that meet the requirements of each
25 State in the Region concerning mandated benefits.

1 Any premium adjustments for such modified plans
2 shall be based only on the cost of the added benefits.

3 (4) The development of guidelines concerning
4 rules for enrollment periods during which employers
5 may purchase health coverage through the Ex-
6 change. Such guidelines shall provide employers op-
7 erating in States that have adopted the necessary
8 laws and regulations provided for in subsection (c),
9 not less than 12 months for initial enrollment once
10 an Exchange is determined to be operational by the
11 Regional Board.

12 (5) Assessing employers that purchase health
13 coverage after the close of the initial enrollment pe-
14 riod a reasonable late enrollment penalty unless such
15 employers are able to provide evidence of credible
16 coverage (as provided for in a manner similar to
17 that provided for under section 2701 of the Public
18 Health Service Act) section prior to enrollment in a
19 health plan in the Exchange.

20 **SEC. 7. HEALTH PLAN OFFERED THROUGH AN EXCHANGE.**

21 (a) IN GENERAL.—To be eligible to offer health care
22 coverage through an Exchange, a health insurance issuer
23 shall—

24 (1) be licensed in each State within the Region
25 in which the issuer operates or sells policies;

1 (2) offer at least the standard benefit package
2 developed under section 4(b)(4), and may offer other
3 options as approved by the Regional Board under
4 section 6;

5 (3) meet quality and efficiency performance and
6 reporting requirements established by the National
7 Policy Board under section 4;

8 (4) rate its insurance products based on the
9 small group market guidelines of the Region in
10 which the product is being offered; and

11 (5) comply with State network adequacy and all
12 other consumer protection laws.

13 (b) REPORTING REQUIREMENTS FOR HEALTH
14 PLANS.—

15 (1) IN GENERAL.—As a condition of offering
16 health care coverage through the Exchange, a health
17 insurance issuer shall report to consumers, the Re-
18 gional Board, and the National Policy Board, infor-
19 mation concerning quality, cost, administration, and
20 structure with respect to health plans offered by the
21 issuer. The National Policy Board, in collaboration
22 with the Institute of Medicine, may update and mod-
23 ify reporting requirements for purposes of this para-
24 graph on an annual basis.

1 (2) QUALITY.—A health insurance issuer, with
2 respect to a health plan offered through an Ex-
3 change, shall collect, analyze, and report to the Na-
4 tional Policy Board and consumers, information on
5 measures of health care quality. Such measures
6 shall—

7 (A) include evidence-based measures of ef-
8 fectiveness, efficiency, patient satisfaction, and
9 other measures as determined appropriate by
10 the National Policy Board; and

11 (B) at a minimum, incorporate existing
12 quality measurement requirements by health
13 plan accrediting entities, including measures in-
14 cluded in the Healthcare Effectiveness Data
15 and Information Set (HEDIS), and the Con-
16 sumer Assessment of Health Plan Survey ad-
17 ministered by the Agency for Healthcare Re-
18 search and Quality.

19 (3) COSTS.—A health insurance issuer, with re-
20 spect to a health plan offered through an Exchange,
21 shall report to the public and the National Policy
22 Board information concerning cost transparency,
23 through the provision of cost-sharing and common
24 cost estimates for medical procedures, health serv-
25 ices and prescription drugs for network hospitals

1 and providers. Such cost-sharing and costs estimates
2 shall include—

- 3 (A) hospital and emergency room fees;
- 4 (B) imaging and radiology;
- 5 (C) laboratories and testing;
- 6 (D) medical supplies and equipment;
- 7 (E) physician office services and therapy
8 services;
- 9 (F) costs for prescription drugs; and
- 10 (G) other data that the National Policy
11 Board determines appropriate.

12 (4) ADMINISTRATION; STRUCTURE.—A health
13 insurance issuer, with respect to a health plan of-
14 fered through an Exchange, shall report to the Na-
15 tional Policy Board information concerning—

- 16 (A) hospital and provider networks;
- 17 (B) methods of utilization management;
- 18 (C) economic and demographic data on en-
19 rollment, revenues, costs, and profits, which
20 may include medical loss ratios;
- 21 (D) benefit packages;
- 22 (E) consumer disputes and complaints filed
23 and resolved; and
- 24 (F) solvency and reserves.

1 (5) SUBMISSION.—Reporting required under
 2 this subsection shall be submitted in print and elec-
 3 tronic formats on at least an annual basis.

4 **SEC. 8. REFUNDABLE CREDIT FOR HEALTH INSURANCE**
 5 **COVERAGE.**

6 (a) IN GENERAL.—Subpart C of part IV of sub-
 7 chapter A of chapter 1 of the Internal Revenue Code of
 8 1986 (relating to refundable credits) is amended by redес-
 9 ignating section 36 as section 37 and by inserting after
 10 section 35 the following new section:

11 **“SEC. 36. HEALTH INSURANCE COSTS.**

12 “(a) ALLOWANCE OF CREDIT.—In the case of an eli-
 13 gible individual, there shall be allowed as a credit against
 14 the tax imposed by this subtitle for the taxable year an
 15 amount equal to the applicable percentage of the pre-
 16 miums paid by or on behalf of the taxpayer for qualified
 17 health insurance during such taxable year.

18 “(b) ELIGIBLE INDIVIDUAL.—For purposes of this
 19 section—

20 “(1) IN GENERAL.—Except as provided in para-
 21 graph (2), the term ‘eligible individual’ means—

22 “(A) any employee of a qualifying small
 23 employer residing in a State which—

24 “(i) has adopted and is applying the
 25 common rating guidelines developed under

1 section 6 of the Affordable Coverage for
2 Small Employers Act of 2008 in the small
3 group market of such State, or

4 “(ii) has been permitted by the Na-
5 tional Policy Board to opt out of the re-
6 quirement of subparagraph (A), pursuant
7 to section 6(d)(2)(G) of such Act, or

8 “(B) any other individual residing in such
9 State who is permitted to purchase qualified
10 health insurance by a Regional Health Coverage
11 Exchange Board under section 6(d)(2)(D) of
12 such Act.

13 “(2) EXCEPTIONS.—Such term shall not in-
14 clude any individual for any month if, as of the first
15 day of such month, such individual—

16 “(A) is entitled to any benefits under title
17 XVIII of the Social Security Act,

18 “(B) is eligible for the program under title
19 XIX or XXI of such Act,

20 “(C) is entitled to any benefit under—

21 “(i) chapter 89 of title 5, United
22 States Code,

23 “(ii) chapter 55 of title 10, United
24 States Code,

1 “(iii) chapter 17 of title 38, United
2 States Code, or

3 “(iv) any medical care program under
4 the Indian Health Care Improvement Act,
5 or

6 “(D) is imprisoned under Federal, State,
7 or local authority.

8 “(c) APPLICABLE PERCENTAGE.—For purposes of
9 this section—

10 “(1) IN GENERAL.—The applicable percentage
11 is equal to, in the case of a taxpayer with modified
12 adjusted gross income for the preceding taxable
13 year—

14 “(A) not exceeding 150 percent of the Fed-
15 eral poverty level (as defined in section 673(2)
16 of the Community Services Block Grant Act
17 (42 U.S.C. 9902(2)) applicable to a family of
18 the size involved, 25 percent,

19 “(B) exceeding 150 percent but not ex-
20 ceeding 200 percent of such Federal poverty
21 level, 20 percent,

22 “(C) exceeding 200 percent but not exceed-
23 ing 250 percent of such Federal poverty level,
24 15 percent,

1 “(D) exceeding 250 percent but not ex-
2 ceeding 300 percent of such Federal poverty
3 level, 10 percent, and

4 “(E) exceeding 300 percent of such Fed-
5 eral poverty level, 0 percent.

6 “(2) MODIFIED ADJUSTED GROSS INCOME.—
7 The term ‘modified adjusted gross income’ means
8 adjusted gross income determined without regard to
9 sections 103, 135, 911, 931 and 933.

10 “(d) QUALIFYING SMALL EMPLOYER.—For purposes
11 of this section—

12 “(1) IN GENERAL.—The term ‘qualifying small
13 employer’ means any small employer which is located
14 in a State described in subsection (b)(1)(A).

15 “(2) SMALL EMPLOYER.—

16 “(A) IN GENERAL.—The term ‘small em-
17 ployer’ means, with respect to a plan year, an
18 employer who employed an average of at least
19 2 but not more than 100 full-time employees on
20 business days during the preceding calendar
21 year and who employs at least 2 employees on
22 the first day of the plan year. Such term may
23 include employers described in section
24 6(d)(2)(E) of the Affordable Coverage for Small
25 Employers Act of 2008 and a sole proprietor if

1 determined appropriate by a Regional Health
2 Coverage Exchange Board.

3 “(B) APPLICATION OF CERTAIN RULES IN
4 DETERMINATION OF EMPLOYER SIZE.—For
5 purposes of this paragraph—

6 “(i) APPLICATION OF AGGREGATION
7 RULE FOR EMPLOYERS.—All persons treat-
8 ed as a single employer under subsection
9 (b), (c), (m), or (o) of section 414 shall be
10 treated as 1 employer.

11 “(ii) EMPLOYERS NOT IN EXISTENCE
12 IN PRECEDING YEAR.—In the case of an
13 employer which was not in existence
14 throughout the preceding calendar year,
15 the determination of whether such em-
16 ployer is a small or large employer shall be
17 based on the average number of employees
18 that it is reasonably expected such em-
19 ployer will employ on business days in the
20 current calendar year.

21 “(iii) PREDECESSORS.—Any reference
22 to an employer shall include a reference to
23 any predecessor of such employer.

1 “(3) EMPLOYER.—The term ‘employer’ has the
2 meaning given such term under section 3(5) of the
3 Employee Retirement Income Security Act of 1974.

4 “(e) QUALIFIED HEALTH INSURANCE.—For pur-
5 poses of this section, the term ‘qualified health insurance’
6 means any health plan offered through a Regional Health
7 Coverage Exchange established under section 6 of the Af-
8 fordable Coverage for Small Employers Act of 2008 with
9 standard benefit package coverage developed under section
10 4(b)(4) of such Act or a plan with benefits that are similar
11 to or not less than the actuarial value of health benefits
12 coverage under the standard benefit package.

13 “(f) OTHER DEFINITIONS.—For purposes of this sec-
14 tion, any term used in this section which is also used in
15 the Affordable Coverage for Small Employers Act of 2008
16 shall have the meaning given such term by such Act.

17 “(g) ARCHER MSA AND HEALTH SAVINGS ACCOUNT
18 CONTRIBUTIONS.—

19 “(1) IN GENERAL.—If a deduction would (but
20 for paragraph (2)) be allowed under section 220 or
21 223 to the taxpayer for a payment for the taxable
22 year to the Archer MSA or health savings account
23 of an individual, subsection (a) shall be applied by
24 treating such payment as a payment for qualified
25 health insurance for such individual.

1 “(2) DENIAL OF DOUBLE BENEFIT.—No deduc-
2 tion shall be allowed under section 220 or 223 for
3 that portion of the payments otherwise allowable as
4 a deduction under section 220 or 223 for the taxable
5 year which is equal to the amount of credit allowed
6 for such taxable year by reason of this subsection.

7 “(h) SPECIAL RULES.—For purposes of this sec-
8 tion—

9 “(1) MARRIED COUPLES MUST FILE JOINT RE-
10 TURN.—

11 “(A) IN GENERAL.—If the taxpayer is
12 married at the close of the taxable year, the
13 credit shall be allowed under subsection (a) only
14 if the taxpayer and his spouse file a joint return
15 for the taxable year.

16 “(B) MARITAL STATUS; CERTAIN MARRIED
17 INDIVIDUALS LIVING APART.—Rules similar to
18 the rules of paragraphs (3) and (4) of section
19 21(e) shall apply for purposes of this para-
20 graph.

21 “(2) DENIAL OF CREDIT TO DEPENDENTS.—No
22 credit shall be allowed under this section to any indi-
23 vidual with respect to whom a deduction under sec-
24 tion 151 is allowable to another taxpayer for a tax-

1 able year beginning in the calendar year in which
2 such individual's taxable year begins.

3 “(3) DENIAL OF DOUBLE BENEFIT.—No credit
4 shall be allowed under subsection (a) if the credit
5 under section 35 is allowed and no credit shall be al-
6 lowed under 35 if a credit is allowed under this sec-
7 tion.

8 “(4) COORDINATION WITH DEDUCTION FOR
9 HEALTH INSURANCE COSTS.—In the case of a tax-
10 payer who is eligible to deduct any amount under
11 section 162(l) or 213 for the taxable year, this sec-
12 tion shall apply only if the taxpayer elects not to
13 claim any amount as a deduction under such section
14 for such year.

15 “(5) MEDICAL AND HEALTH SAVINGS AC-
16 COUNTS.—The credit allowed under subsection (a)
17 for any taxable year shall be reduced by the aggre-
18 gate amount distributed from Archer MSAs (as de-
19 fined in section 220(d)) and health savings accounts
20 (as defined in section 223(d)) which are excludable
21 from gross income for such taxable years by reason
22 of being used to pay premiums for coverage of an
23 individual under qualified health insurance for any
24 month.

1 “(6) ELECTION NOT TO CLAIM CREDIT.—This
2 section shall not apply to a taxpayer for any taxable
3 year if such taxpayer elects to have this section not
4 apply for such taxable year.

5 “(7) VERIFICATION OF COVERAGE, ETC.—No
6 credit shall be allowed under this section with re-
7 spect to any individual unless such individual’s cov-
8 erage (and such related information as the Secretary
9 may require) is verified in such manner as the Sec-
10 retary may prescribe.

11 “(8) INSURANCE WHICH COVERS OTHER INDI-
12 VIDUALS; TREATMENT OF PAYMENTS.—Rules similar
13 to the rules of paragraphs (7) and (8) of section
14 35(g) shall apply for purposes of this section.

15 “(i) REDUCTION IN CREDIT FOR ADVANCE PAY-
16 MENTS.—With respect to any taxable year, the amount
17 which would (but for this subsection) be allowed as a cred-
18 it to the taxpayer under subsection (a) shall be reduced
19 (but not below zero) by the aggregate amount paid on be-
20 half of such taxpayer under section 7529 for months be-
21 ginning in such taxable year.

22 “(j) REGULATIONS.—The Secretary shall prescribe
23 such regulations and other guidance as may be necessary
24 or appropriate to carry out the purposes of this section,
25 section 6050X, and section 7529, including the application

1 of the credit with respect to eligible individuals described
2 in subsection (b)(1)(B).”.

3 (b) INFORMATION REPORTING.—

4 (1) IN GENERAL.—Subpart B of part III of
5 subchapter A of chapter 61 of the Internal Revenue
6 Code of 1986 (relating to information concerning
7 transactions with other persons) is amended by in-
8 serting after section 6050W the following new sec-
9 tion:

10 **“SEC. 6050X. RETURNS RELATING TO PAYMENTS FOR**
11 **QUALIFIED HEALTH INSURANCE.**

12 “(a) IN GENERAL.—Any person who, in connection
13 with a trade or business conducted by such person, re-
14 ceives payments during any calendar year from any indi-
15 vidual for coverage of such individual or any other indi-
16 vidual under creditable health insurance, shall make the
17 return described in subsection (b) (at such time as the
18 Secretary may by regulations prescribe) with respect to
19 each individual from whom such payments were received.

20 “(b) FORM AND MANNER OF RETURNS.—A return
21 is described in this subsection if such return—

22 “(1) is in such form as the Secretary may pre-
23 scribe, and

24 “(2) contains—

1 “(A) the name, address, and TIN of the
2 individual from whom payments described in
3 subsection (a) were received,

4 “(B) the name, address, and TIN of each
5 individual who was provided by such person
6 with coverage under creditable health insurance
7 by reason of such payments and the period of
8 such coverage, and

9 “(C) such other information as the Sec-
10 retary may reasonably prescribe.

11 “(c) CREDITABLE HEALTH INSURANCE.—For pur-
12 poses of this section, the term ‘creditable health insurance’
13 means qualified health insurance (as defined in section
14 36(e)) other than, to the extent provided in regulations
15 prescribed by the Secretary, any other insurance covering
16 an individual if no credit is allowable under section 36
17 with respect to such coverage.

18 “(d) STATEMENTS TO BE FURNISHED TO INDIVID-
19 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
20 QUIRED.—Every person required to make a return under
21 subsection (a) shall furnish to each individual whose name
22 is required under subsection (b)(2)(A) to be set forth in
23 such return a written statement showing—

1 “(1) the name and address of the person re-
2 quired to make such return and the phone number
3 of the information contact for such person,

4 “(2) the aggregate amount of payments de-
5 scribed in subsection (a) received by the person re-
6 quired to make such return from the individual to
7 whom the statement is required to be furnished, and

8 “(3) the information required under subsection
9 (b)(2)(B) with respect to such payments.

10 The written statement required under the preceding sen-
11 tence shall be furnished on or before January 31 of the
12 year following the calendar year for which the return
13 under subsection (a) is required to be made.

14 “(e) RETURNS WHICH WOULD BE REQUIRED TO BE
15 MADE BY 2 OR MORE PERSONS.—Except to the extent
16 provided in regulations prescribed by the Secretary, in the
17 case of any amount received by any person on behalf of
18 another person, only the person first receiving such
19 amount shall be required to make the return under sub-
20 section (a).”.

21 (2) ASSESSABLE PENALTIES.—

22 (A) Subparagraph (B) of section
23 6724(d)(1) of such Code (relating to defini-
24 tions) is amended by striking “or” at the end
25 of clause (xxi), by striking “and” at the end of

1 clause (xxii) and inserting “or”, and by adding
2 after clause (xxii) the following new clause:

3 “(xxiii) section 6050X (relating to re-
4 turns relating to payments for qualified
5 health insurance),”.

6 (B) Paragraph (2) of section 6724(d) of
7 such Code is amended by striking “or” at the
8 end of subparagraph (CC), by striking the pe-
9 riod at the end of subparagraph (DD) and in-
10 serting “, or” and by adding at the end the fol-
11 lowing new subparagraph:

12 “(EE) section 6050X(d) (relating to re-
13 turns relating to payments for qualified health
14 insurance).”.

15 (3) CLERICAL AMENDMENT.—The table of sec-
16 tions for subpart B of part III of subchapter A of
17 chapter 61 of such Code is amended by inserting
18 after the item relating to section 6050W the fol-
19 lowing new item:

“Sec. 6050X. Returns relating to payments for qualified health insurance.”.

20 (c) CONFORMING AMENDMENTS.—

21 (1) Paragraph (2) of section 1324(b) of title
22 31, United States Code, is amended by inserting be-
23 fore the period “, or from section 36 of such Code”.

24 (2) The table of sections for subpart C of part
25 IV of subchapter A of chapter 1 of the Internal Rev-

1 “(2) for whom a qualified health insurance
2 credit eligibility certificate is in effect.

3 “(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGI-
4 BILITY CERTIFICATE.—For purposes of this section, a
5 qualified health insurance credit eligibility certificate is a
6 statement furnished by an individual to the Secretary
7 which—

8 “(1) certifies that the individual will be eligible
9 to receive the credit provided by section 36 for the
10 taxable year,

11 “(2) estimates the amount of such credit for
12 such taxable year, and

13 “(3) provides such other information as the
14 Secretary may require for purposes of this section.

15 “(d) QUALIFIED HEALTH INSURANCE CREDIT AD-
16 VANCE AMOUNT.—For purposes of this section, the term
17 ‘qualified health insurance credit advance amount’ means,
18 with respect to any provider of qualified health insurance,
19 the Secretary’s estimate of the amount of credit allowable
20 under section 36 to the individual for the taxable year
21 which is attributable to the insurance provided to the indi-
22 vidual by such provider.”.

23 (2) CLERICAL AMENDMENT.—The table of sec-
24 tions for chapter 77 of the Internal Revenue Code

1 of 1986 is amended by adding at the end the fol-
2 lowing new item:

“Sec. 7529. Advance payment of health insurance credit for purchasers of
qualified health insurance.”.

3 (3) **EFFECTIVE DATE.**—The amendments made
4 by this section shall apply to taxable years beginning
5 after December 31, 2008.

6 **SEC. 9. REFUNDABLE CREDIT FOR SMALL EMPLOYER**
7 **HEALTH INSURANCE EXPENSES.**

8 (a) **IN GENERAL.**—Subpart C of part IV of sub-
9 chapter A of chapter 1 of the Internal Revenue Code of
10 1986 (relating to refundable credits), as amended by sec-
11 tion 8, is amended by inserting after section 36 the fol-
12 lowing new section:

13 **“SEC. 36A. SMALL EMPLOYER HEALTH INSURANCE EX-**
14 **PENSES.**

15 “(a) **DETERMINATION OF AMOUNT.**—In the case of
16 a qualifying small employer, there shall be allowed as a
17 credit against the tax imposed by this subtitle for the tax-
18 able year an amount equal to the applicable percentage
19 of the employer’s contribution during such taxable year
20 towards the cost of qualified employee health insurance
21 expenses. No amount paid or incurred pursuant to a sal-
22 ary reduction arrangement shall be taken into account
23 under the preceding sentence.

1 “(b) APPLICABLE PERCENTAGE.—For purposes of
2 subsection (a), the applicable percentage is equal to, in
3 the case of an employer contribution of—

4 “(1) at least 50 but less than 60 percent of the
5 cost of qualified employee health insurance expenses,
6 10 percent,

7 “(2) at least 60 but less than 70 percent of
8 such cost, 15 percent,

9 “(3) at least 70 but less than 80 percent of
10 such cost, 20 percent, and

11 “(4) at least 80 percent of such cost, 25 per-
12 cent.

13 “(c) DEFINITIONS.—For purposes of this section—

14 “(1) QUALIFYING SMALL EMPLOYER.—The
15 term ‘qualifying small employer’ has the meaning
16 given such term by section 36(d).

17 “(2) QUALIFIED EMPLOYEE HEALTH INSUR-
18 ANCE EXPENSES.—

19 “(A) IN GENERAL.—The term ‘qualified
20 employee health insurance expenses’ means any
21 expenses for qualified health insurance (as de-
22 fined in section 36(e)) to the extent attributable
23 to coverage—

24 “(i) provided to any employee while
25 such employee is a qualified employee, or

1 “(ii) for the employer, in the case of
2 a sole proprietor.

3 “(B) QUALIFIED EMPLOYEE.—The term
4 ‘qualified employee’ means any individual de-
5 scribed in section 36(b) (determined without re-
6 gard to paragraph (1)(B) thereof).

7 “(d) CERTAIN RULES MADE APPLICABLE.—For pur-
8 poses of this section, rules similar to the rules of section
9 52 shall apply.

10 “(e) COORDINATION WITH ADVANCE PAYMENTS OF
11 CREDIT.—With respect to any taxable year, the amount
12 which would (but for this subsection) be allowed as a cred-
13 it to the taxpayer under subsection (a) shall be reduced
14 by the aggregate amount paid on behalf of such taxpayer
15 under section 7530 for months beginning in such taxable
16 year. If the amount determined under this subsection is
17 less than zero, the taxpayer shall owe additional tax in
18 such amount under this chapter.

19 “(f) CREDITS FOR NONPROFIT ORGANIZATIONS.—
20 Any credit which would be allowable under subsection (a)
21 with respect to a qualifying small employer if such quali-
22 fying small employer were not exempt from tax under this
23 chapter shall be treated as a credit allowable under this
24 subpart to such qualifying small employer.”.

1 (b) ADVANCE PAYMENTS OF CREDIT.—Chapter 77
2 of the Internal Revenue Code of 1986, as amended by sec-
3 tion 8, is amended by inserting after section 7529 the fol-
4 lowing new section:

5 **“SEC. 7530. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
6 **INSURANCE COSTS FOR QUALIFYING SMALL**
7 **EMPLOYERS.**

8 “(a) GENERAL RULE.—Not later than December 31,
9 2008, the Secretary shall establish a program for making
10 monthly payments on behalf of any qualifying small em-
11 ployer to providers of qualified health insurance for quali-
12 fied employees of such employer. The amount of the
13 monthly payment for a qualifying small employer shall be
14 one twelfth of the amount of the credit for the tax year
15 to which the qualifying small employer is entitled under
16 section 36A. If a monthly payment is made by the Sec-
17 retary for which the employer is not entitled to a cor-
18 responding credit, the employer shall owe additional tax
19 in such amount under this chapter.

20 “(b) DEFINITIONS.—Any term used in this section
21 which is also used in section 36A shall have the meaning
22 given such term by section 36A.”.

23 (c) CONFORMING AMENDMENTS.—

1 (1) Paragraph (2) of section 1324(b) of title
2 31, United States Code, as amended by section 8, is
3 amended by inserting “or 36A” after “36”.

4 (2) The table of sections for subpart C of part
5 IV of subchapter A of chapter 1 of the Internal Rev-
6 enue Code of 1986, as amended by section 8, is
7 amended by inserting after the item relating to sec-
8 tion 36 the following new item:

“Sec. 36A. Small employer health insurance expenses.”.

9 (3) The table of sections for chapter 77 of such
10 Code, as amended by section 8, is amended by add-
11 ing at the end the following new item:

“Sec. 7530. Advance payment of credit for health insurance costs for qualifying
small employers.”.

12 (d) **EFFECTIVE DATE.**—The amendments made by
13 this section shall apply to amounts paid or incurred in tax-
14 able years beginning after December 31, 2008.

15 **SEC. 10. REPORTS AND EVALUATIONS.**

16 (a) **ANNUAL REPORT TO CONGRESS.**—Not later than
17 1 year after the date of enactment of this Act, and bienni-
18 ally thereafter, the Governmental Accountability Office
19 shall submit to the National Policy Board and the appro-
20 priate committees of Congress a report concerning the ac-
21 tivities of the National Policy Board and the Regional
22 Boards under this Act.

1 (b) INSTITUTE OF MEDICINE.—Not later than 6
2 months after the date of enactment of this Act, and annu-
3 ally thereafter, the National Policy Board shall contract
4 with the Institute of Medicine to review and make rec-
5 ommendations concerning the standard benefit package
6 developed under section 4 and submit such recommenda-
7 tions to the National Policy Board and the appropriate
8 committees of Congress.

9 **SEC. 11. REPORTING INSURANCE STATUS.**

10 The Secretary of the Treasury shall develop a process
11 to enable individuals to report the health insurance status
12 of each member in their household on their Federal in-
13 come tax return.

○