

109TH CONGRESS
1ST SESSION

S. 637

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

IN THE SENATE OF THE UNITED STATES

MARCH 16, 2005

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

A BILL

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

- 1 *Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*
- 2 **SECTION 1. SHORT TITLE.**
- 3 This Act may be cited as the “Small Employers
- 4 Health Benefits Program Act of 2005”.

1 **SEC. 2. DEFINITIONS.**

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

6 (b) OTHER TERMS.—In this Act:

7 (1) EMPLOYEE.—The term “employee” has the
8 meaning given such term under section 3(6) of the
9 Employee Retirement Income Security Act of 1974
10 (29 U.S.C. 1002(6)). Such term shall not include an
11 employee of the Federal Government.

12 (2) EMPLOYER.—The term “employer” has the
13 meaning given such term under section 3(5) of the
14 Employee Retirement Income Security Act of 1974
15 (29 U.S.C. 1002(5)), except that such term shall in-
16 clude only employers who employed an average of at
17 least 1 but not more than 100 employees on busi-
18 ness days during the year preceding the date of ap-
19 plication. Such term shall not include the Federal
20 Government.

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

25 (4) OFFICE.—The term “Office” means the Of-
26 fice of Personnel Management.

7 (c) APPLICATION OF CERTAIN RULES IN DETER-
8 MINATION OF EMPLOYER SIZE.—For purposes of sub-
9 section (b)(2):

10 (1) APPLICATION OF AGGREGATION RULE FOR
11 EMPLOYERS.—All persons treated as a single em-
12 ployer under subsection (b), (c), (m), or (o) of sec-
13 tion 414 of the Internal Revenue Code of 1986 shall
14 be treated as 1 employer.

4 (d) WAIVER AND CONTINUATION OF PARTICIPA-
5 TION.—

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

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

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

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

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

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

14 (3) any other change that would adversely af-
15 fect the coverage afforded under such chapter 89 to
16 employees and annuitants and members of family
17 under that chapter.

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

21 (e) CONTRACTS FOR ADMINISTRATION.—The Office
22 may enter into contracts for the performance of appro-
23 priate administrative functions under this Act.

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

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

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

9 **SEC. 4. CONTRACT REQUIREMENT.**

10 (a) IN GENERAL.—The Office may enter into con-
11 tracts with qualified carriers offering health benefits plans
12 of the type described in section 8903 or 8903a of title
13 5, United States Code, without regard to section 5 of title
14 41, United States Code, or other statutes requiring com-
15 petitive bidding, to provide health insurance coverage to
16 employees of participating employers under this Act. Each
17 contract shall be for a uniform term of at least 1 year,
18 but may be made automatically renewable from term to
19 term in the absence of notice of termination by either
20 party. In entering into such contracts, the Office shall en-
21 sure that health benefits coverage is provided for individ-
22 uals only, married individuals without children, and fami-
23 lies.

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

5 (c) STATEMENT OF BENEFITS.—

16 (d) STANDARDS.—The minimum standards pre-
17 scribed for health benefits plans under section 8902(e) of
18 title 5, United States Code, and for carriers offering plans,
19 shall apply to plans and carriers under this Act. Approval
20 of a plan may be withdrawn by the Office only after notice
21 and opportunity for hearing to the carrier concerned with-
22 out regard to subchapter II of chapter 5 and chapter 7
23 of title 5, United States Code.

24 (e) CONVERSION.—

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

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

16 (f) RATES.—Rates charged under health benefits
17 plans under this Act shall reasonably and equitably reflect
18 the cost of the benefits provided. Such rates shall be deter-
19 mined on a basis which, in the judgment of the Office,
20 is consistent with the lowest schedule of basic rates gen-
21 erally charged for new group health benefits plans issued
22 to large employers. The rates determined for the first con-
23 tract term shall be continued for later contract terms, ex-
24 cept that they may be readjusted for any later term, based
25 on past experience and benefit adjustments under the later

1 contract. Any readjustment in rates shall be made in ad-
2 vance of the contract term in which they will apply and
3 on a basis which, in the judgment of the Office, is con-
4 sistent with the general practice of carriers which issue
5 group health benefits plans to large employers. Rates
6 charged for coverage under this Act shall not vary based
7 on health-status related factors.

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

16 **SEC. 5. ELIGIBILITY.**

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

19 (1) is an employee of an employer described in
20 section 2(b)(2), or is a self employed individual as
21 defined in section 401(c)(1)(B) of the Internal Rev-
22 enue Code of 1986; and

23 (2) is not otherwise enrolled or eligible for en-
24 rollment in a plan under chapter 89 of title 5,
25 United States Code.

1 **SEC. 6. ALTERNATIVE CONDITIONS TO FEDERAL EM-**
2 **PLOYEE PLANS.**

3 (a) TREATMENT OF EMPLOYEE.—For purposes of
4 enrollment in a health benefits plan under this Act, an
5 individual who had coverage under a health insurance plan
6 and is not a qualified beneficiary as defined under section
7 4980B(g)(1) of the Internal Revenue Code of 1986 shall
8 be treated in a similar manner as an individual who begins
9 employment as an employee under chapter 89 of title 5,
10 United States Code.

11 (b) PREEXISTING CONDITION EXCLUSIONS.—

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

16 (2) EXCLUSION PERIOD.—

17 (A) IN GENERAL.—A preexisting condition
18 exclusion under this subsection shall provide for
19 coverage of a preexisting condition to begin not
20 later than 6 months after the date on which the
21 coverage of the individual under a health bene-
22 fits plan commences, reduced by 1 month for
23 each month that the individual was covered
24 under a health insurance plan immediately pre-
25 ceding the date the individual submitted an ap-
26 plication for coverage under this Act.

7 (c) RATES AND PREMIUMS.—

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

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

20 (D) shall be adjusted to cover the adminis-
21 trative costs of the Office under this Act.

22 (2) DETERMINATIONS.—In determining rates
23 and premiums under this Act, the following provi-
24 sions shall apply:

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

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

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

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

(B) AGE ADJUSTMENTS.—

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

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

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

4 (iii) LIMITATION.—In making an ad-
5 justment to premium rates under subpara-
6 graph (A)(iii), a carrier shall ensure that
7 such adjustment does not result in an av-
8 erage premium rate applicable to enrollees
9 under the plan involved that is more than
10 200 percent of the lowest rate for all age
11 groups.

12 (d) TERMINATION AND REENROLLMENT.—If an indi-
13 vidual who is enrolled in a health benefits plan under this
14 Act terminates the enrollment, the individual shall not be
15 eligible for reenrollment until the first open enrollment pe-
16 riod following the expiration of 6 months after the date
17 of such termination.

18 (e) PREEMPTION.—

19 (1) HEALTH INSURANCE OR PLANS.—

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

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

3 (B) LOCAL PLANS.—With respect to a con-
4 tract entered into under this Act under which
5 a carrier will offer health benefits plan coverage
6 in a limited geographic area, subparagraph (A)
7 shall not apply to the extent that a mandated
8 benefit law is in effect in the State in which the
9 plan is offered. Such mandated benefit law shall
10 continue to apply to such health benefits plan.

11 (C) RATING RULES.—The rating require-
12 ments under subsection (c)(2) shall supercede
13 State rating rules for qualified plans under this
14 Act.

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

17 (A) any State or local law or regulation ex-
18 cept those laws and regulations described in
19 subparagraphs (A) and (C) of paragraph (1);
20 and

21 (B) State network adequacy laws.

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

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

3 **SEC. 7. ENCOURAGING PARTICIPATION BY CARRIERS**
4 **THROUGH ADJUSTMENTS FOR RISK.**

5 (a) **APPLICATION OF RISK CORRIDORS.—**

6 (1) **IN GENERAL.**—This section shall only apply
7 to carriers with respect to health benefits plans of-
8 fered under this Act during any of calendar years
9 2006 through 2010.

10 (2) **NOTIFICATION OF COSTS UNDER THE**
11 **PLAN.**—In the case of a carrier that offers a health
12 benefits plan under this Act in any of calendar years
13 2006 through 2010, the carrier shall notify the Of-
14 fice, before such date in the succeeding year as the
15 Office specifies, of the total amount of costs incurred
16 in providing benefits under the health benefits plan
17 for the year involved and the portion of such costs
18 that is attributable to administrative expenses.

19 (3) **ALLOWABLE COSTS DEFINED.**—For pur-
20 poses of this section, the term “allowable costs”
21 means, with respect to a health benefits plan offered
22 by a carrier under this Act, for a year, the total
23 amount of costs described in paragraph (2) for the
24 plan and year, reduced by the portion of such costs

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

3 (b) ADJUSTMENT OF PAYMENT.—

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

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

14 (A) COSTS BETWEEN 103 AND 108 PER-
15 CENT OF TARGET AMOUNT.—If the allowable
16 costs for the carrier with respect to the health
17 benefits plan involved for the year are greater
18 than 103 percent, but not greater than 108
19 percent, of the target amount for the plan and
20 year, the Office shall reimburse the carrier for
21 such excess costs through payment to the car-
22 rier of an amount equal to 75 percent of the
23 difference between such allowable costs and 103
24 percent of such target amount.

1 (B) COSTS ABOVE 108 PERCENT OF TAR-
2 GET AMOUNT.—If the allowable costs for the
3 carrier with respect to the health benefits plan
4 involved for the year are greater than 108 per-
5 cent of the target amount for the plan and
6 year, the Office shall reimburse the carrier for
7 such excess costs through payment to the car-
8 rier in an amount equal to the sum of—

9 (i) 3.75 percent of such target
10 amount; and

11 (ii) 90 percent of the difference be-
12 tween such allowable costs and 108 percent
13 of such target amount.

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

16 (A) COSTS BETWEEN 92 AND 97 PERCENT
17 OF TARGET AMOUNT.—If the allowable costs for
18 the carrier with respect to the health benefits
19 plan involved for the year are less than 97 per-
20 cent, but greater than or equal to 92 percent,
21 of the target amount for the plan and year, the
22 carrier shall be required to pay into the contin-
23 gency reserve fund maintained under section
24 8909(b)(2) of title 5, United States Code, an
25 amount equal to 75 percent of the difference

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

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

11 (i) 3.75 percent of such target
12 amount; and

13 (ii) 90 percent of the difference be-
14 tween 92 percent of such target amount
15 and such allowable costs.

16 (4) TARGET AMOUNT DESCRIBED.—

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

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

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

3 (ii) the amount of administrative ex-
4 penses that the carrier estimates, and the
5 Office approves, will be incurred by the
6 carrier with respect to the plan for such
7 calendar year.

8 (B) SUBMISSION OF TARGET AMOUNT.—
9 Not later than December 31, 2005, and each
10 December 31 thereafter through calendar year
11 2009, a carrier shall submit to the Office a de-
12 scription of the target amount for such carrier
13 with respect to health benefits plans provided
14 by the carrier under this Act.

15 (c) DISCLOSURE OF INFORMATION.—

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

18 (A) that a carrier offering a health benefits
19 plan under this Act shall provide the Office
20 with such information as the Office determines
21 is necessary to carry out this subsection includ-
22 ing the notification of costs under subsection
23 (a)(2) and the target amount under subsection
24 (b)(4)(B); and

1 (B) that the Office has the right to inspect
2 and audit any books and records of the organi-
3 zation that pertain to the information regarding
4 costs provided to the Office under such sub-
5 sections.

14 (a) ESTABLISHMENT.—The Office shall establish a
15 reinsurance fund to provide payments to carriers that ex-
16 perience one or more catastrophic claims during a year
17 for health benefits provided to individuals enrolled in a
18 health benefits plan under this Act.

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

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

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

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

5 (c) PAYMENT.—

6 (1) IN GENERAL.—The amount of a payment
7 from the reinsurance fund to a carrier under this
8 section for a catastrophic episode of care shall be de-
9 termined by the Office but shall not exceed an
10 amount equal to 80 percent of the applicable cata-
11 strophic claim amount.

12 (2) APPLICABLE CATASTROPHIC CLAIM
13 AMOUNT.—For purposes of paragraph (1), the appli-
14 cable catastrophic episode of care amount shall be
15 equal to the difference between—

16 (A) the amount of the catastrophic claim;
17 and

18 (B) \$50,000.

19 (3) LIMITATION.—In determining the amount
20 of a payment under paragraph (1), if the amount of
21 the catastrophic claim exceeds the amount that
22 would be paid for the healthcare items or services in-
23 volved under title XVIII of the Social Security Act
24 (42 U.S.C. 1395 et seq.), the Office shall use the

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

3 (d) DEFINITION.—In this section, the term “cata-
4 strophic claim” means a claim submitted to a carrier, by
5 or on behalf of an enrollee in a health benefits plan under
6 this Act, that is in excess of \$50,000.

7 **SEC. 9. CONTINGENCY RESERVE FUND.**

8 Beginning on October 1, 2010, the Office may use
9 amounts appropriated under section 14(a) that remain un-
10 obligated to establish a contingency reserve fund to pro-
11 vide assistance to carriers offering health benefits plans
12 under this Act that experience unanticipated financial
13 hardships (as determined by the Office).

14 **SEC. 10. EMPLOYER PARTICIPATION.**

15 (a) REGULATIONS.—The Office shall prescribe regu-
16 lations providing for employer participation under this
17 Act, including the offering of health benefits plans under
18 this Act to employees.

19 (b) ENROLLMENT AND OFFERING OF OTHER COV-
20 ERAGE.—

21 (1) ENROLLMENT.—A participating employer
22 shall ensure that each eligible employee has an op-
23 portunity to enroll in a plan under this Act.

24 (2) PROHIBITION ON OFFERING OTHER COM-
25 PREHENSIVE HEALTH BENEFIT COVERAGE.—A par-

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

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

7 (B) is offered only through the enrollment
8 process established by the Office under section
9 3.

10 (3) OFFER OF SUPPLEMENTAL COVERAGE OP-
11 TIONS.—

12 (A) IN GENERAL.—A participating em-
13 ployer may offer supplementary coverage op-
14 tions to employees.

15 (B) DEFINITION.—In subparagraph (A),
16 the term “supplementary coverage” means ben-
17 efits described as “excepted benefits” under
18 section 2791(c) of the Public Health Service
19 Act (42 U.S.C. 300gg–91(c)).

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

1 **SEC. 11. ADMINISTRATION THROUGH REGIONAL ADMINIS-**2 **TRATIVE ENTITIES.**

3 (a) IN GENERAL.—In order to provide for the admin-
4 istration of the benefits under this Act with maximum effi-
5 ciency and convenience for participating employers and
6 health care providers and other individuals and entities
7 providing services to such employers, the Office is author-
8 ized to enter into contracts with eligible entities to per-
9 form, on a regional basis, one or more of the following:

10 (1) Collect and maintain all information relat-
11 ing to individuals, families, and employers partici-
12 pating in the program under this Act in the region
13 served.

14 (2) Receive, disburse, and account for payments
15 of premiums to participating employers by individ-
16 uals in the region served, and for payments by par-
17 ticipating employers to carriers.

18 (3) Serve as a channel of communication be-
19 tween carriers, participating employers, and individ-
20 uals relating to the administration of this Act.

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

25 (5) The processing of grievances and appeals.

1 (b) APPLICATION.—To be eligible to receive a con-
2 tract under subsection (a), an entity shall prepare and
3 submit to the Office an application at such time, in such
4 manner, and containing such information as the Office
5 may require.

6 (c) PROCESS.—

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

10 (2) REQUIREMENT.—No contract shall be en-
11 tered into with any entity under this section unless
12 the Office finds that such entity will perform its ob-
13 ligations under the contract efficiently and effec-
14 tively and will meet such requirements as to finan-
15 cial responsibility, legal authority, and other matters
16 as the Office finds pertinent.

17 (3) PUBLICATION OF STANDARDS AND CRI-
18 TERIA.—The Office shall publish in the Federal
19 Register standards and criteria for the efficient and
20 effective performance of contract obligations under
21 this section, and opportunity shall be provided for
22 public comment prior to implementation. In estab-
23 lishing such standards and criteria, the Office shall
24 provide for a system to measure an entity's perform-
25 ance of responsibilities.

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

16 (1) a description of the duties of the con-
17 tracting entity;

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

1 paragraph (2) and otherwise to carry out the pur-
2 poses of this Act;

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

10 SEC. 12. COORDINATION WITH SOCIAL SECURITY BENE-
11 FITS.

12 Benefits under this Act shall, with respect to an indi-
13 vidual who is entitled to benefits under part A of title
14 XVIII of the Social Security Act, be offered (for use in
15 coordination with those medicare benefits) to the same ex-
16 tent and in the same manner as if coverage were under
17 chapter 89 of title 5, United States Code.

18 SEC. 13. PUBLIC EDUCATION CAMPAIGN.

19 (a) IN GENERAL.—In carrying out this Act, the Of-
20 fice shall develop and implement an educational campaign
21 to provide information to employers and the general public
22 concerning the health insurance program developed under
23 this Act.

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

1 under subsection (a), the Office shall submit to the appro-
2 priate committees of Congress a report that describes the
3 activities of the Office under subsection (a), including a
4 determination by the office of the percentage of employers
5 with knowledge of the health benefits programs provided
6 for under this Act.

7 (c) PUBLIC EDUCATION CAMPAIGN.—There is au-
8 thorized to be appropriated to carry out this section, such
9 sums as may be necessary for each of fiscal years 2006
10 and 2007.

11 **SEC. 14. APPROPRIATIONS.**

12 (a) MANDATORY APPROPRIATIONS.—There are au-
13 thorized to be appropriated, and there are appropriated,
14 to carry out sections 7 and 8—

15 (1) \$4,000,000,000 for fiscal year 2006;
16 (2) \$4,000,000,000 for fiscal year 2007;
17 (3) \$4,000,000,000 for fiscal year 2008;
18 (4) \$3,000,000,000 for fiscal year 2009; and
19 (5) \$3,000,000,000 for fiscal year 2010.

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

1 **SEC. 15. REFUNDABLE CREDIT FOR SMALL BUSINESS EM-**2 **PLOYEE HEALTH INSURANCE EXPENSES.**

3 (a) IN GENERAL.—Subpart C of part IV of sub-
4 chapter A of chapter 1 of the Internal Revenue Code of
5 1986 (relating to refundable credits) is amended by redes-
6 ignating section 36 as section 37 and inserting after sec-
7 tion 35 the following new section:

8 **“SEC. 36. SMALL BUSINESS EMPLOYEE HEALTH INSURANCE**9 **EXPENSES.**

10 “(a) DETERMINATION OF AMOUNT.—In the case of
11 a qualified small employer, there shall be allowed as a
12 credit against the tax imposed by this subtitle for the tax-
13 able year an amount equal to the sum of—

14 “(1) the expense amount described in sub-
15 section (b), and

16 “(2) the expense amount described in sub-
17 section (c), paid by the taxpayer during the taxable
18 year.

19 “(b) SUBSECTION (b) EXPENSE AMOUNT.—For pur-
20 poses of this section—

21 “(1) IN GENERAL.—The expense amount de-
22 scribed in this subsection is the applicable percent-
23 age of the amount of qualified employee health in-
24 surance expenses of each qualified employee.

25 “(2) APPLICABLE PERCENTAGE.—For purposes
26 of paragraph (1)—

1 “(A) IN GENERAL.—The applicable per-
2 centage is equal to—

3 “(i) 25 percent in the case of self-only
4 coverage,

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

8 “(iii) 30 percent in the case of cov-
9 erage for married adults with no children.

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

18 “(c) SUBSECTION (c) EXPENSE AMOUNT.—For pur-
19 poses of this section—

20 “(1) IN GENERAL.—The expense amount de-
21 scribed in this subsection is, with respect to the first
22 credit year of a qualified small employer which is an
23 eligible employer, 10 percent of the qualified em-
24 ployee health insurance expenses of each qualified
25 employee.

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

6 “(3) ELIGIBLE EMPLOYER.—For purposes of
7 paragraph (1), the term ‘eligible employer’ shall not
8 include a qualified small employer if, during the 3-
9 taxable year period immediately preceding the first
10 credit year, the employer or any member of any con-
11 trolled group including the employer (or any prede-
12 cessor of either) established or maintained health in-
13 surance coverage for substantially the same employ-
14 ees as are the qualified employees to which the
15 qualified employee health insurance expenses relate.

16 “(d) LIMITATION BASED ON WAGES.—

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

23 “(2) AMOUNT OF REDUCTION.—

24 “(A) IN GENERAL.—The percentage deter-
25 mined under this paragraph is the percentage

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

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

20 “(1) QUALIFIED SMALL EMPLOYER.—The term
21 ‘qualified small employer’ means any employer (as
22 defined in section 2(b)(2) of the Small Employers
23 Health Benefits Program Act of 2005) which—

24 “(A) is a participating employer (as de-
25 fined in section 2(b)(5) of such Act), and

1 “(B) pays or incurs at least 60 percent of
2 the qualified employee health insurance ex-
3 penses of each qualified employee.

4 “(2) **QUALIFIED EMPLOYEE HEALTH INSUR-**
5 **ANCE EXPENSES.—**

6 “(A) **IN GENERAL.**—The term ‘qualified

7 employee health insurance expenses’ means any

8 amount paid by an employer for health insur-

9 ance coverage under such Act to the extent

10 such amount is attributable to coverage pro-

11 vided to any employee while such employee is a

12 qualified employee.

13 “(B) **EXCEPTION FOR AMOUNTS PAID**

14 **UNDER SALARY REDUCTION ARRANGEMENTS.—**

15 No amount paid or incurred for health insur-

16 ance coverage pursuant to a salary reduction

17 arrangement shall be taken into account under

18 subparagraph (A).

19 “(3) **QUALIFIED EMPLOYEE.—**

20 “(A) **IN GENERAL.**—The term ‘qualified

21 employee’ means, with respect to any period, an

22 employee (as defined in section 2(b)(1) of such

23 Act) of an employer if the total amount of

24 wages paid or incurred by such employer to

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

3 “(B) WAGES.—The term ‘wages’ has the
4 meaning given such term by section 3121(a)
5 (determined without regard to any dollar limita-
6 tion contained in such section).

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

10 “(g) CREDITS FOR NONPROFIT ORGANIZATIONS.—
11 Any credit which would be allowable under subsection (a)
12 with respect to a qualified small business if such qualified
13 small business were not exempt from tax under this chap-
14 ter shall be treated as a credit allowable under this sub-
15 part to such qualified small business.”.

16 (b) CONFORMING AMENDMENTS.—

17 (1) Paragraph (2) of section 1324(b) of title
18 31, United States Code, is amended by inserting be-
19 fore the period “, or from section 36 of such Code”.

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

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

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

4 **SEC. 16. EFFECTIVE DATE.**

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

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