of renunciation and allegiance required to be naturalized as a citizen of the United States, to encourage and support the efforts of prospective citizens of the United States to become citizens, and for other purposes.

S. 1922

At the request of Mr. CONRAD, the name of the Senator from Oklahoma (Mr. COBURN) was added as a cosponsor of S. 1922, a bill to authorize appropriate action if negotiations with Japan to allow the resumption of United States beef exports are not successful, and for other purposes.

S. 1925

At the request of Mr. KENNEDY, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1925, a bill to provide for workers and businesses during the response to Hurricane Katrina and Hurricane Rita, and for other purposes.

S. 1947

At the request of Mr. SUNUNU, the names of the Senator from Georgia (Mr. CHAMBLISS) and the Senator from Ohio (Mr. DEWINE) were added as cosponsors of S. 1947, a bill to amend chapter 21 of title 38, United States Code, to enhance adaptive housing assistance for disabled veterans.

S. RES. 219

At the request of Mrs. FEINSTEIN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. Res. 219, a resolution designating March 8, 2006, as ''Endangered Species Day'', and encouraging the people of the United States to become educated about, and aware of, threats to species, success stories in species recovery, and the opportunity to promote species conservation worldwide.

AMENDMENT NO. 2351

At the request of Mr. CONRAD, the names of the Senator from Maryland (Ms. MIKULSKI), the Senator from New York (Mrs. CLINTON) and the Senator from Delaware (Mr. BIDEN) were added as cosponsors of amendment No. 2351 proposed to S. 1932, an original bill to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95).

AMENDMENT NO. 2353

At the request of Mrs. MURRAY, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from New York (Mrs. CLINTON) were added as cosponsors of amendment No. 2353 intended to be proposed to S. 1932, an original bill to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95).

AMENDMENT NO. 2354

At the request of Mr. NELSON of Florida, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of amendment No. 2354 intended to be proposed to S. 1932, an original bill to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95).

AMENDMENT NO. 2355

At the request of Mr. INHOFE, the names of the Senator from South Carolina (Mr. DEMINT), the Senator from Georgia (Mr. ISAKSON), the Senator from Arizona (Mr. KYL) and the Senator from Oklahoma (Mr. COBURN) were added as cosponsors of amendment No. 2355 proposed to S. 1932, an original bill to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95).

AMENDMENT NO. 2357

At the request of Mr. NELSON of Florida, the names of the Senator from New York (Mrs. CLINTON), the Senator from Minnesota (Mr. DAYTON), the Senator from Maryland (Ms. MIKULSKI) and the Senator from Wisconsin (Mr. KOHL) were added as cosponsors of amendment No. 2357 proposed to S. 1932, an original bill to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95).

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KENNEDY (for himself and Mr. DEWINE):

S. 1951. A bill to amend the Public Health Service Act to help individuals with functional impairments and their families pay for services and supports that they need to maximize their functionality and independence and have choices about community participation, education, and employment, and for other purposes; to the Committee on Finance.

Mr. KENNEDY. Mr. President, it's a privilege to join Senator DEWINE in introducing this bipartisan legislation to build on the promise and possibilities of the Americans with Disabilities Act.

Our bill, the Community Living Assistance Services and Supports Act—the CLASS Act—will help large numbers of Americans who struggle everyday to live productive lives in their communities.

Too many Americans are perfectly capable of living a life in the community, but are denied the supports they need.

They languish in needless circumstances with no choice about how or where to obtain these services.

Too often, they have to give up the American Dream the dignity of a job, a home, and a family—so they can qualify for Medicaid, the only program that will support them.

The bill we propose is a long overdue effort to offer greater dignity, greater hope, and greater opportunity.

It makes a simple pact with all Americans—''If you work hard and contribute, society will take care of you when you fall on hard times.''

The concept is clear—everyone can contribute and everyone can win. We all benefit when no one is left behind.

For only $30 a month, a person who pays into the program will receive either $50 or $100 a day, based on their ability to carry out basic daily activities.

They themselves will decide how this assistance will be spent—on transportation so they can stay employed, or on a ramp to make their home more accessible, or to cover the cost of a personal care attendant or a family caregiver.

It will help keep families together—instead of being torn apart by obstacles that discourage them from staying at home.

The bill will strengthen job opportunities for people with disabilities at a time when 70 percent are unemployed. They have so much to contribute and the bill will help them do it.

It will save on the mushrooming health care costs for Medicaid, the Nation's primary insurer of long-term care services, which also forces beneficiaries to give up their jobs and live in poverty before they become eligible for assistance.

The CLASS Act is a hopeful new approach to restoring independence and choice for millions of these persons and enabling them to take greater control of their lives.

It's time to respect the rights and dignity of all Americans, and I look forward to working with Senator DEWINE and other colleagues to see this bill enacted into law.

I ask unanimous consent that a summary of the CLASS Act legislation be printed in the RECORD.

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

SUMMARY OF THE DEWINE-KENNEDY CLASS ACT OF 2005—(COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS ACT)

PURPOSE OF THE BILL

To help adults with severe functional impairments obtain the services and supports they need to stay functional and independent, while providing them with choices about community participation, education and employment.

BACKGROUND

Currently there are 10 million Americans in need of long term services and supports, and the number is expected to increase to near 15 million by 2020.

Most private-sector disability or long-term care insurance plans are constrained in the insurance protection they can offer at an affordable price, and neither Supplemental Security Insurance (SSI) nor Old, Age, Survivors, and Disability Insurance (OASDI) programs have any benefit differentials related to the extent and character of the disability.

Thus, most Americans who have or develop severe functional impairments can only access coverage for the services critical to their independence (such as housing modifications, assistive technologies, transportation, and personal assistance services), through Medicaid. Their reliance on Medicaid for critical support services creates a strong incentive for them to ''spend down'' assets and remain poor and unemployed. With Medicaid paying 50 percent of the costs of long term services, increased expenditures on long term services are expected to add $44 billion annually to the cost of Medicaid over the next decade.

OVERVIEW OF THE LEGISLATION

The CLASS Act will offer an alternative path. It will create a new national insurance

program to help adults who have or develop functional impairments to remain independent, employed, and stay a part of their community.

Financed through voluntary payroll deductions of $30.00 per month, without enrollment like Medicare Part B, this legislation will help remove barriers to independence and choice, e.g., housing modification, assistive technologies, personal assistance services, transportation, that can be overwhelmingly costly, by providing a cash benefit to those individuals who are unable to perform 2 or more functional activities of daily living.

The large risk pool to be created by this program approach will make added coverage much more affordable than it is currently, thereby reducing the incentives for people with severe impairments to ''spend down'' to Medicaid. It will give individuals added choice and access to supports without requiring them to become impoverished to qualify.

The CLASS Act is an important step in the evolution of public policy toward a new focus on helping individuals overcome barriers to independence that they may confront due to severe functional impairments. It is an important extension of concepts embodied in the Individuals with Disabilities Education Act (IDEA), the Americans with Disabilities Act of 1990 (ADA), and Ticket to Work and Work Incentives Improvement Act of 1999.

SPECIFICS OF THE BILL

Scope

The CLASS Act will establish a national insurance program, financed by voluntary premium payments to be collected through payroll withholding and placed in a ''National Independence Fund.'' The Department of Health and Human Services will manage the Fund as a new insurance program, and may enter into contractual agreements with those entities that states direct to assume administrative/program implementation roles.

Enrollment in the Program

Any individual who is at least 18 years old and actively working will be automatically enrolled, unless they opt out, and pay their premiums through payroll deduction or another alternative method. Any non-working spouse may enroll in the program and pay their premiums through an alternative payment procedure.

Triggering the Benefit

To qualify for CLASS Act benefits, individuals must be at least 18 years old and have contributed to the program during at least 5 years. Eligibility for benefits will be determined by state disability determination centers and will be limited to: 1. individuals who are unable to perform two or more activities of daily living (ADL) e.g. eating, bathing, dressing, or 2. individuals who have an equivalent cognitive disability that requires supervision or hands-on assistance to perform those activities, e.g. traumatic brain injury, Alzheimer's disease, multiple sclerosis, mental retardation.

Benefits

To account for differences in independence support needs, there will be two cash benefit tiers.

Tier 1 benefits $50/day, will be payable to eligible individuals who are unable to perform 2 or more ADLs or have the equivalent cognitive impairment.

Tier 2 benefits $100/day, will be payable to individuals who are unable to perform 4 or ore ADL's or have the equivalent cognitive impairment.

The monthly case benefit will be posted monthly to a debit account or a ''Choice Account''. Individuals who do not use the full monthly amount may roll it over from month to month, but not year to year.

However, once an individual becomes ineligible for CLASS benefits (by improvement in functional status or death), CLASS Act benefits will cease. Any residual balance of available services remaining on the individual's account will not be payable. If an eligible individual does choose to move into an institutional facility, CLASS Act benefits will be used to defray those associated expenses.

Relationship of CLASS Act Insurance Program to Social Security Disability Insurance

Eligibility for CLASS Act benefits will be independent of whether or not an individual is eligible for SSDI, so participation in the CLASS Act insurance program will not impair an individual's ability to remain qualified for SSDI.

Relationship of CLASS Act Insurance Program to Social Security Retirement Benefits

Similarly, eligibility for CLASS Act benefits will be independent of retirement benefits eligibility.

Relationship to Medicaid

If an individual is eligible for CLASS Act benefits, and are also eligible for the long term care benefit under Medicaid, CLASS Act benefits can be used to offset the costs to Medicaid, thus producing Medicaid savings for the state.

Relationship to Private Long Term Care Insurance

The ''Class'' program benefit does not replace the need for basic health insurance—it provides a mechanism to pay for those non-medical expenses that allow a disabled person to remain independent,

The ''Class'' program benefit can be an addition to long term care insurance. It provides a consistent, basic cash benefit to glove with the insurance products that provide more intense medical services over a shorter period of time.

Mr. DEWINE. Mr. President, I am pleased to join Senator KENNEDY today in introducing the Community Living Assistance Services and Supports Act—or the CLASS Act.

Unfortunately, most Americans are not prepared for the costs of long-term services and supports when they arise. High premiums have discouraged many Americans from purchasing long-term care insurance in the private market. Furthermore, underwriting practices have excluded individuals with existing disabilities from purchasing plans.

Right now, 10 million people suffer from severe functional impairments and by 2020 that number will have increased to 15 million. Therefore, in the next 15 years, we will experience a 50 percent growth in the number of persons with severe functional impairments. Some of those people will be struck suddenly—through accidents or sudden illness. And the reality is that any one of us here today could face sudden impairment and disability. We won't see it coming until it happens, and most of us will not be prepared to provide for necessary, long-term care needs.

Some people may end up with a degenerative disease, such as Parkinson's disease, which leads to increased impairments. They may know now what their needs will be, but are unable to purchase private insurance due to this pre-existing condition. Others will age and develop other physical or cognitive impairments, such as Alzheimer's disease.

Although we know that age is inevitable, we are not properly preparing for this eventuality or the possibility of sudden accidents and many people are financially unable to purchase available insurance due to the high price. However, the fact remains that millions of Americans will need the services that the CLASS Act seeks to provide.

The CLASS Act will help Americans to remain independent in their communities by creating a new long-term care insurance program. This program will be available to all working Americans above the age of 18. For only $30 per individual each month, and a minimum of 20 quarters of payments, the CLASS Act will help those who do not have adequate long-term care insurance due to cost or current disability. This bill will allow people to choose the supports they need when and if they become severely impaired. It will help them remain independent. It will help them remain in their communities. It will help them remain with their families.

This is a good bill. I thank Senator KENNEDY for his work on this bill, and I encourage my colleagues to support it.

By Mr. COLEMAN (for himself, Mr. BAYH, Mr. CORNYN, and Mr. LUGAR):

S. 1952. A bill to provide grants for rural health information technology development activities; to the Committee on Health, Education, Labor, and Pensions.

Mr. COLEMAN. Mr. President, as United States Senators, we are well aware of the rising cost of health care and the difficulty of health care access in rural areas. Through the improvement of health information technology, we will see overall productivity and quality improvements to our health care system. New technologies make the system more efficient and effective by diagnosing diseases sooner, providing preventive and ongoing managed care.

Today, I am proud to be joined by my friends, Senators BAYH, CORNYN, and LUGAR, in introducing the Critical Access to Health Information Technology Act to help Critical Access Hospitals compete for health information technology grants.

Our legislation would give smaller rural health hospitals a competitive edge for health information technology grants. A health system technology infrastructure should be encouraged and facilitated as broadly and rapidly as possible to help reduce medical errors, improve quality of care and reduce rising health care costs.

A recent American Hospitals Association study shows that while 9 out of 10 hospitals are using or considering using health information technology

for clinical uses, most cite cost as a major impediment to broader adoption, especially for small or rural hospitals. The study suggests that the use of health information technology in caring for patients is evolving as hospitals adopt specific technologies based on their needs and priorities, size and financial resources.

The Critical Access to Health Information Technology Act creates a grant program administered by the Secretary of Health and Human Services in conjunction with State agencies for improving health information technology in our Nation's rural areas. In addition, this legislation supports the next generation of coding system, ICD–10, that will modernize and expand Centers for Medicare and Medicaid Services' capacity to keep pace with changes in medical practice and technology. ICD–10 was developed as an improvement to ICD–9 which has not been updated since 1980. The adoption of ICD–10 will allow for far more accurate, detailed and descriptive coding, and will allow the system to adapt as future changes are warranted. The transition to ICD–10 is time-sensitive, as the number of available ICD–9 codes is rapidly dwindling.

Earlier this Congress, I, along with Senator PRYOR, introduced the bipartisan ''Rural Renaissance II Act.'' This is a bipartisan piece of legislation, based on earlier legislation introduced last year, which would establish a private-public partnership to provide bonds that will finance grants that will fund key rural development projects to address critical rural infrastructure problems. I am pleased that Chairman GRASSLEY has agreed to include our Rural Renaissance Act II in his tax reconciliation package later this year.

These bonds will be made available to small rural communities of 50,000 or fewer for: water and waste facilities, affordable housing, community facilities, including hospitals, fire and police stations, and nursing and assisted living facilities, farmer-owned value-added agriculture or renewable energy projects, including ethanol, biodiesel and wind, distance learning and telemedicine and high speed internet access and rural teleworks projects.

I urge my fellow colleagues to join me in ensuring Critical Access Hospitals have the opportunity to keep pace with health information technology by supporting the Critical Access to Health Information Technology Act.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1952

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Critical Access to Health Information Technology Act of 2005''.

SEC. 2. HEALTH INFORMATION TECHNOLOGY GRANT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish and implement a program to award grants to increase access to health care in rural areas by improving health information technology, including the reporting, monitoring, and evaluation required under this section.

(b) STATE GRANTS.—The Secretary shall award grants to States to be used to carry out the State plan under subsection (e) through the awarding of subgrants to local entities within the State. Amounts awarded under such a grant may only be used in the fiscal year in which the grant is awarded or in the immediately subsequent fiscal year.

(c) AMOUNT OF GRANT.—From amounts appropriated under subsection (k) for each fiscal year, the Secretary shall award a grant to each State that complies with subsection (e) in an amount that is based on the total number of critical access hospitals in the State (as certified by the Secretary under section 1817(e) of the Social Security Act) bears to the total number of critical access hospitals in all States that comply with subsection (e).

(d) LEAD AGENCY.—A State that receives a grant under this section shall designate a lead agency to—

(1) administer, directly or through other governmental or nongovernmental agencies, the financial assistance received under the grant;

(2) develop, in consultation with appropriate representatives of units of general purpose local government and the hospital association of the State, the State plan; and

(3) coordinate the expenditure of funds and provision of services under the grant with other Federal and State health care programs.

(e) STATE PLAN.—To be eligible for a grant under this section, a State shall establish a State plan that shall—

(1) identify the State's lead agency;

(2) provide that the State shall use the amounts provided to the State under the grant program to address health information technology improvements and to pay administrative costs incurred in connection with providing the assistance to local grant recipients;

(3) provide that benefits shall be available throughout the entire State; and

(4) require that the lead agency consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds received under the grant.

(f) AWARDING OF LOCAL GRANTS.—

(1) IN GENERAL.—The lead agency of a State shall use amounts received under a grant under subsection (a) to award local grants on a competitive basis. In determining whether a local entity is eligible to receive a grant under this subsection, the lead agency shall utilize the following selection criteria:

(A) The extent to which the entity demonstrates a need to improve its health information reporting and health information technology.

(B) The extent to which the entity will serve a community with a significant low-income or other medically underserved population.

(2) APPLICATION AND APPROVAL.—To be eligible to receive a local grant under this subsection, an entity shall be a government-owned or private nonprofit hospital (including a non-Federal short-term general acute care facility that is a critical access hospital located outside a Metropolitan Statistical Area, in a rural census tract of a Metropolitan Statistical Area as determined under the most recent version of the Goldsmith Modification or the Rural-Urban Commuting Area codes, as determined by the Office of Rural Health Policy of the Health Resources and Services Administration, or is located in an area designated by any law or regulation of the State in which the hospital is located as a rural area (or is designated by such State as a rural hospital or organization)) that submits an application to the lead agency of the State that—

(A) includes a description of how the hospital intends to use the funds provided under the grant;

(B) includes such information as the State lead agency may require to apply the selection criteria described in paragraph (1);

(C) includes measurable objectives for the use of the funds provided under the grant;

(D) includes a description of the manner in which the applicant will evaluate the effectiveness of the activities carried out under the grant;

(E) contains an agreement to maintain such records, make such reports, and cooperate with such reviews or audits as the lead agency and the Secretary may find necessary for purposes of oversight of program activities and expenditures;

(F) contains a plan for sustaining the activities after Federal support for the activities has ended; and

(G) contains such other information and assurances as the Secretary may require.

(3) USE OF AMOUNTS.—

(A) IN GENERAL.—An entity shall use amounts received under a local grant under this section to—

(i) offset the costs incurred by the entity after December 31, 2005, that are related to clinical health care information systems and health information technology designed to improve quality of health care and patient safety; and

(ii) offset costs incurred by the entity after December 31, 2005, that are related to enabling health information technology to be used for the collection and use of clinically specific data, promoting the interoperability of health care information across health care settings, including reporting to Federal and State agencies, and facilitating clinic decision support through the use of health information technology.

(B) ELIGIBLE COSTS.—Costs that are eligible to be offset under subparagraph (A) shall include the cost of—

(i) purchasing, leasing, and installing computer software and hardware, including handheld computer technologies, and related services;

(ii) making improvements to existing computer software and hardware;

(iii) purchasing or leasing communications capabilities necessary for clinical data access, storage, and exchange;

(iv) services associated with acquiring, implementing, operating, or optimizing the use of new or existing computer software and hardware and clinical health care information systems;

(v) providing education and training to staff on information systems and technology designed to improve patient safety and quality of care; and

(vi) purchasing, leasing, subscribing, integrating, or servicing clinical decision support tools that integrate patient-specific clinic data with well-established national treatment guidelines, and provide ongoing continuous quality improvement functions that allow providers to assess improvement rates over time and against averages for similar providers.

(4) GRANT LIMIT.—The amount of a local grant under this subsection shall not exceed $250,000.

(g) REPORTING, MONITORING, AND EVALUATION.—The lead agency of a State that receives a grant under this section shall annually report to the Secretary—

(1) the amounts received under the grant;

(2) the amounts allocated to State grant recipients under the grant;

(3) the breakdown of types of expenditures made by the local grant recipients with such funds; and

(4) such other information required by the Secretary to assist the Secretary in monitoring the effectiveness of activities carried out under this grant.

(h) REVIEW OF COMPLIANCE WITH STATE PLAN.—The Secretary shall review and monitor State compliance with the requirements of this section and the State plan submitted under subsection (e). If the Secretary, after reasonable notice to a State and opportunity for a hearing, finds that there has been a failure by the State to comply substantially with any provision or requirement set forth in the State plan or the requirements of this section, the Secretary shall notify the lead agency involved of such finding and that no further payments to the State will be made with respect to the grant until the Secretary is satisfied that the State is in compliance or that the noncompliance will be promptly corrected.

(i) PREEMPTION OF CERTAIN LAWS.—The provisions of this section shall preempt applicable Federal and State procurement laws with respect to health information technology purchased under this section.

(j) RELATION TO OTHER PROGRAMS.—Amounts appropriated under this section shall be in addition to appropriations for Federal programs for Rural Hospital FLEX grants, Rural Health Outreach grants, and Small Rural Hospital Improvement Program grants.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for each of fiscal years 2006 through 2008.

SEC. 3. REPLACEMENT OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES.

(a) IN GENERAL.—Not later than October 1, 2006, the Secretary of Health and Human Services shall promulgate a final rule concerning the replacement of the International Statistical Classification of Diseases, 9th revision, Clinical Modification (referred to in this section as the ''ICD-9-CM''), under the regulation promulgated under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)), including for purposes of part A of title XVIII, or part B where appropriate, of such Act, with the use of each of the following:

(1) The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (referred to in this section as ''ICD-10-CM''.

(2) The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification Coding System (referred to in this section as ''ICD-10-PCS'').

(b) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall ensure that the rule promulgated under subsection (a) is implemented by not later than October 1, 2009. In carrying out the preceding sentence, the Secretary shall ensure that such rule ensure that Accredited Standards Committee X12 HIPAA transactions version (v) 4010 is upgraded to a newer version 5010, and that the National Council for Prescription Drug Programs Telecommunications Standards version 5.1 is updated to a newer version (to be released by the named by the National Council for Prescription Drug Programs Telecommunications Standards) that supersedes, in part, existing legislation and regulations under the Health Insurance Portability and Accountability Act of 1996.

(2) AUTHORITY.—The Secretary of Health and Human Services shall have the authority to adopt, without notice and comment rulemaking, standards for electronic health care transactions under section 1173 of the Social Security Act (42 U.S.C. 1320d-2) that are recommended to the Secretary by the Accredited Standards Committee X12 of the American National Standards Institute in relation to the replacement of ICD-9-CM with ICD-10-CM and ICD-10-PCS. Such modifications shall be published in the Federal Register.

(c) NOTICE OF INTENT.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall issue and publish in the Federal Register a Notice of Intent that—

(1) adoption of Accredited Standards Committee X12 HIPAA transactions version (v) 5010 shall occur not later than April 1, 2007, and compliance with such rule shall apply to transactions occurring on or after April 1, 2009;

(2) adoption of the National Council for Prescription Drug Programs Telecommunications Standards version 5.1 with a new version will occur not later than April 1, 2007, and compliance with such rule shall apply to transactions occurring on or after April 1, 2009;

(3) adoption of ICD-10-CM and ICD-10-PCS will occur not later than October 1, 2006, and compliance with such rules shall apply to transactions occurring on or after October 1, 2009; and

(4) covered entities and health technology vendors under the Health Insurance Potability and Accountability Act of 1996 shall begin the process of planning for and implementing the updating of the new versions and editions referred to in this subsection.

(d) ASSURANCES OF CODE AVAILABILITY.—The Secretary of Health and Human Services shall take such action as may be necessary to ensure that procedure codes are promptly available for assignment and use under ICD-9-CM until such time as ICD-9-CM is replaced as a code set standard under section 1173(c) of the Social Security Act with ICD-10 PCS.

(e) DEADLINE.—Notwithstanding section 1172(f) of the Social Security Act (42 U.S.C. 1320d-1(f)), the Secretary of Health and Human Services shall adopt the modifications provided for in this section without a recommendation of the National Committee on Vital and Health Statistics unless such recommendation is made to the Secretary on or before a date specified by the Secretary as consistent with the implementation of the replacement of ICD-9-CM with ICD-10-CM and ICD-10-PCS for transactions occurring on or after October 1, 2009.

(f) LIMITATION ON JUDICIAL REVIEW.—The rule promulgated under subsection (a) shall not be subject to judicial review.

(g) APPLICATION.—The rule promulgated under subsection (a) shall apply to transactions occurring on or after October 1, 2009.

(h) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as effecting the application of classification methodologies or codes, such as the Current Procedural Terminology (CPT) as maintained and distributed by the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS) as maintained and distributed by the Department of Health and Human Services, other than under the International Statistical Classification of Disease and Related Health Problems.

By Mr. ENZI (for himself, Mr. NELSON of Nebraska, and Mr. BURNS):

S. 1955. A bill to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; to the Committee on Health, Education, Labor, and Pensions.

Mr. ENZI. Mr. President, together with Senator NELSON of Nebraska and Senator BURNS, I am pleased today to introduce ''The Health Insurance Marketplace Modernization and Affordability Act of 2005.'' This is a bipartisan effort aimed at relieving the worsening crisis of cost and coverage in America's health insurance system.

As I speak today, we are nearing almost five years of double-digit growth in health insurance premiums—increases that have repeatedly exceeded more than five times the rate of inflation. Since 2000, for example, group premiums for family coverage have grown nearly 60 percent, compared to an underlying inflation rate of 9.7 percent over the same period.

Those hardest hit are America's small businesses and those individuals outside of employer-provided insurance. These are the ones with the least market leverage and the weakest ability to pool risk. Already, among the very smallest of our businesses, those with fewer than 10 employees, only 52 percent offer coverage to their employees.

As a former small business owner, I understand the difficulties these employers face when trying to provide health insurance for their employees.

A constituent of mine, Mitchell Blake of Jackson, WY recently told me his story, and it illustrates what is happening to thousands of small businesses across America. Mr. Blake owns a small architecture firm with eight employees. He believes, like so many small business owners across America, that providing insurance for his employees not only promotes a healthy workforce but is simply the right thing to do.

In the nine years since his firm opened, the deductibles for employees' health insurance quadrupled, co-pays rose by more than 35 percent, and monthly premiums grew by 20 percent. Since 2001, the company's profits have dropped by nearly one-third, due in large part to providing health insurance coverage.

I am realistic. The biggest drivers of health care costs are ones that defy short-term solutions. These include advances in costly medical treatments, Americans' continuing appetite for such treatments, lack of transparency in pricing, and an outdated third-party payment system that insulates consumers from seeing the true cost of care they receive. Addressing these deep problems in a fundamental way will require years of effort and a great deal of political will.

And yet, like most members in this body, I am hearing an ever-growing

chorus of concern from my constituents about health insurance—and most especially from small businesses.

America's families and small businesses don't want us to wait for the perfect solution or the perfect moment. They need real help, and they need it now.

Recognizing this increasing concern, and as the new Chairman of the Senate's Health, Education, Labor and Pensions Committee, I have made it a priority in recent months to seek the counsel of stakeholders, citizens, experts, and fellow members of Congress on how we might come together on a package of health insurance reforms we can realistically hope to enact in this Congress.

The most well known proposal now on the table is the approach known as association health plans, or AHPs. Under this proposal, which was introduced in this Congress by Senators SNOWE and TALENT, qualifying trade associations would be permitted to band together their members for purposes of offering health coverage.

Association health plans hold significant promise—particularly in the pooling of risk, economies of scale, and market clout they could lend to thousands of small businesses.

At the same time, however, the AHP bills in their current form may also go too far in allowing some association plans to play by a separate set of rules than those governing the rest of the small group insurance marketplace—thereby tempting adverse selection and market disruption. Another concern is the fact that the current AHP proposals would shift primary oversight over many association plans away from the states and move it to the federal government.

Regrettably, debate over these AHP pros and cons has hardened into a political and stakeholder stalemate—a stalemate that has helped block constructive action on new health insurance reform for nearly a decade.

It is time we broke this logjam and moved forward.

Toward this end, I sincerely appreciate the hard work of Senators SNOWE and TALENT and other AHP proponents in working with me on possible compromise approaches. And similarly, I am encouraged by what appears to be a growing pragmatic spirit among traditional AHP critics.

The legislation we are introducing today is a compromise approach.

This legislation blends a modified version of the current Snowe/Talent AHP legislation with several additional reform initiatives applicable not just to association plans, but also to the wider health insurance marketplace.

It is built around several fundamental principles, including: 1. giving associations a meaningful role, but on a level playing field; 2. streamlining the current hodgepodge of varying State regulation; 3. preserving the primary role of the States in health insurance oversight and consumer protection; 4. making lower-cost health plan options available; and 5. achieving meaningful reform without a big price tag that could cloud prospects for passage.

With regard to association-based health plans, this bill preserves most of what is known as the ''fully insured'' component of the current AHP bill. That is, like the current AHP bill, my legislation would allow associations to independently pool their members for purposes of buying health coverage, thereby giving them needed strength in numbers and bargaining power.

Unlike the current AHP bill, however, this legislation does not include the much more controversial option for associations to self-insure. Primary regulatory oversight of coverage issued to associations would remain at the state level and would not be transferred to Federal control. Although far from perfect, our state insurance commissions are much closer to the real problems confronted by purchasers of insurance in their communities than would be a Federal agency in Washington.

Like the current AHP bill, this legislation would enable associations to take advantage of more streamlined rules in the areas of benefit design and rating. In an important departure from the current AHP bill, however, this greater streamlining would be made available not just to associations, but also to other purchasers of insurance. This adjustment will go a long way toward easing critics' fears that the current AHP bill would create an unlevel playing field and market disruption.

In short, association-based plans should have the opportunity to harness the advantage of independent pooling and play a commercially meaningful role in the coverage marketplace. However, the coverage offered to association members should be subject to underlying regulatory and consumer protection requirements substantially comparable to those applicable to other entities offering similar coverage.

In addition to addressing coverage offered through associations, the legislation we are introducing today also makes several very important improvements in the health insurance marketplace as a whole.

For example, this legislation would permit issuers of coverage, both to associations and others, to offer lower-cost health plans free from some, though not all, of the current state benefit mandates that have proliferated over the past decade.

Under this bill, those mandates that are currently in place in at least 45 States would continue in effect, but carriers would be permitted to offer plans that do not include other mandated benefits. The intent of this provision is not only to enable the offering of more affordable plan options, but also to make it easier for carriers to offer coverage on a multi-state basis and in more markets.

This legislation would also set in motion a process to create greater harmonization in the current costly and competition-inhibiting hodgepodge of varying State health insurance regulation.

However, even as it moves the system to greater uniformity in the rules applied, this approach would also carefully retain the current structure of State-based oversight and administration of insurance.

This harmonization approach is patterned in general terms after the process used in the early 1990s to achieve greater stability in the Medicare supplemental, Medigap, market.

The bill would establish a harmonization commission under the Secretary of Health and Human Services to develop harmonized standards for health insurance regulation. The commission would work in close consultation with the NAIC and the States, and would consist of members representing a full range of perspectives and stakeholders.

Upon issuance of model standards by the commission and their certification by the Secretary, the States would have two years to adopt them. If a state did not adopt the standards within the required timeframe, an insurer, following certain certification requirements, would be permitted to sell insurance in that State following the harmonized Federal rules.

I want to take a moment to thank Senator GREGG, my predecessor as chairman of the HELP Committee. It is due in no small part to his efforts in the last Congress that health insurance market harmonization has matured in the policy community as a needed and valuable step. I look forward to working with him to make this and other aspects of this legislation as effective as it can possibly be.

It is important to note that responsibility for oversight and management of the insurance market would remain with the States. What would change is that the rules being applied would become more uniform across State lines. This will enable a wider range of plans to be offered, because the offering of insurance on a multi-State basis will become easier. Competition will improve and costs will go down as more plans enter more markets.

This bill reflects and incorporates much thoughtful input from those on many sides of this difficult issue. Such input continues even as I speak. Indeed, there are a number of important issues that remain to be worked on as we proceed with consideration of this bill.

For example, we will be continuing discussions on how to smoothe the interaction between association-based plans and the individual insurance market. Similarly, work remains to be done in the calibration of transition rules, including with respect to the handling of older blocks of business vis a vis new plan options that will arise under the new system. Another issue deserving of further attention is the handling of the way carriers can become licensed in multiple States, and

opportunities for making this process as smooth as possible while maintaining the authority of State insurance commissioners.

I am open to suggestions, and I am open to compromise—but I am not open to continued inaction.

My intention is for this bill to serve as a foundation for the swift finalization and passage of a health insurance reform package that will deliver real relief to America's small businesses and struggling families.

I ask unanimous consent that a summary of the legislation and the text of the bill be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUMMARY: HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY ACT OF 2005

The intent of the Health Insurance Marketplace Modernization and Affordability Act of 2005 is to reduce costs and improve access in the health insurance marketplace, principally though not exclusively in the small group market.

This legislation addresses these goals by blending a modified version of the current AHP legislation—S. 406, introduced by Senators Snowe and Talent with several additional reform initiatives applicable not just to association plans but also to the wider marketplace.

The fundamental principle include: 1. giving associations a meaningful role, but on a level playing field; 2. streamlining the current hodgepodge of varying state regulations; 3. preserving a strong state role in insurance oversight and consumer protection; 4. making lower-cost health plan options available; 5. achieving meaningful reform without a big price tag clouding prospects for passage.

Title I, regarding Small Business Health Plans (SBHPs), resembles the ''fully insured'' component of the S. 406, but does not include that bill's more controversial provisions permitting association plans to self-insure. Associations will be permitted to pool independently from the underlying small group market.

SBHPs may offer coverage free from many but not all benefit mandates, which reflects a different approach but similar intent to that included in S. 406. If a benefit mandate is in place in at least 45 states, an SBHP must follow it, but it may opt out of other mandated benefits. This approach preserves the most widely agreed-upon mandates, but achieves the goal of giving multi-state associations the uniformity they need to operate effectively across State lines.

Associations wishing to establish an SBHP will follow rules very similar to those for AHPs under S. 406, the bill introduced by Senators Snowe and Talent. An SBHP must: 1. be established for purposes other than health coverage; 2. have been in existence for at least 3 years; 3. do not condition association membership or coverage on health status; 4. obtain Federal certification; 5. be governed by a board of directors with complete fiscal control.

This bill also retains primary oversight and supervision of insurance coverage at the State level, and does not shift it to Federal oversight, as parts of S. 406 would require.

Title II, the Near-Term Market Relief section, provides for certain near-term changes in insurance regulation aimed at reducing costs and expanding access. Ultimately, some of these provisions will be superseded by the wider regulatory harmonization process provided in Title III. These provisions will apply not just to association plans (SBHPs) but also to policies sold to others.

Rating Relief: The first section of Title II deals with rating relief. Under Title II, The National Association of Insurance Commissioners (NAIC) model rules regarding rating, the amount that premiums can vary from an insurer's base rate, or average, that are now in effect in nearly half the states would become the interim standard for rating. Currently these NAIC rating rules are in effect in 24 states, and about a dozen others are very close. The NAIC rules require that premiums charged when the policy is issued cannot vary more than +/− 25 percent from the base rate, and +/− 15 percent upon renewal.

Insurers licensed in a given state will be permitted to use the NAIC standard even if State law differs. A graduated transition process will apply for States that currently have rating bands significantly different from the NAIC model.

Lower-Cost Plan Options: The intent of the second provision of Title II is to permit lower-cost plans to be offered that are free from many of the current benefit mandates. Mirroring the approach applied to benefit mandates for SBHPs in Title I, if a benefit mandate is mandated in at least 45 States, an insurer must offer it, but it may opt out of other mandated benefits provided that the exercise of such opt-out is fully disclosed in the policy. This approach preserves the most widely agreed-upon mandates, but allows for greater flexibility in the offering of more affordable coverage options.

Title II, which addresses regulatory harmonization, establishes a process intended to create greater uniformity in the current costly and competition-inhibiting hodgepodge of varying state health insurance regulation. However, even as this moves the system to greater uniformity in rules applied, it also carefully retains the current structure of State-based oversight and administration of insurance.

This approach is patterned in general terms after the process used in the early 1990s to achieve greater stability in the Medicare supplemental, Medigap, market.

To achieve uniformity, this legislation establishes a harmonization commission under HHS to develop uniform standards for insurance regulation. The commission will work in close consultation with the NAIC and the States, and will consist of members representing: 1. State insurance regulators; 2. insurers; 3. business/employer representatives; 4. consumer advocates; 5. agents; 6. providers; 7. high risk pool administrators; and 8. actuaries.

The commission will address these areas of insurance regulation: 1. rating; 2. consumer protections; and 3. access to coverage, such as standards regarding issuance and renewability.

Upon issuance of model standards by the commission and their certification by the Secretary, the States will have two years to adopt them. If a State fails to adopt the standards within the required timeframe, an insurer, following certain certification requirements, will be permitted to sell insurance in that State following the harmonized Federal rules, rather than that State's rules.

Responsibility for oversight and management of the insurance market will remain with the States. What changes is that the rules being applied will become more uniform across State lines, thereby achieving a number of advantages, including: 1. a wider range of plans offered, because offering insurance on a multi-state basis will become easier; 2. improved competition and reduced costs as more plans enter more markets; and 3. reduced administrative costs.

S. 1955

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2005''.

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

TITLE I—SMALL BUSINESS HEALTH PLANS

SEC. 101. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the

applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—a small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small employer health plan involved is failing to comply with the requirements of this part.

''(d) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for small business health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such small business health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 806(a).

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to a small business health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to a small business health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust agreement has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

''(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2005.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers and service providers.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of a small business health plan in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2005, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

''(1) the affiliated member was an affiliated member on the date of certification under this part; or

''(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such small business health plan.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to a small business health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of directors serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

''(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the plan so long as any variation in such rates complies with the requirements of clause (ii); or

''(ii) varying contribution rates for participating employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2005.

''(3) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan, from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2005, provided that, upon issuance by the Secretary of Health and Human Services of the List of Required Benefits as provided for in section 2922(a) of the Public Health Service Act, the required scope and application for each benefit or service listed in the List of Required Benefits shall be—

''(1) if the domicile State mandates such benefit or service, the scope and application required by the domicile State; or

''(2) if the domicile State does not mandate such benefit or service, the scope and application required by the non-domicile State that does require such benefit or service in which the greatest number of the small business health plan's participating employers are located.

''(c) STATE LICENSURE AND INFORMATIONAL FILING.—

''(1) DOMICILE STATE.—Coverage shall be issued to a small business health plan in the State in which the sponsor's principal place of business is located.

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located, an insurer issuing coverage to such small business health plan shall not be required to obtain full licensure in such State, except that the insurer shall provide each State insurance commissioner (or applicable State authority) with an informational filing describing policies sold and other relevant information as may be requested by the applicable State authority.

''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

''(C) in the case of a small business health plan in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2005, a person eligible to be a member of the sponsor or one of its member associations.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and

for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of a small business health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of section 805(a)(2)(B) and (b) (concerning small business health plan rating and benefits) are met.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

(C) by adding at the end the following new clause:

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Certification of small business health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Requirements for application and related requirements.
''807. Notice requirements for voluntary termination.
''808. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 1 year after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—NEAR-TERM MARKET RELIEF

SEC. 201. NEAR-TERM MARKET RELIEF.

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

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE REFORM

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''Subtitle A—Near-Term Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted either the NAIC model rules or the National Interim Model Rating Rules in their entirety and as the exclusive laws of the State that relate to rating in the small group insurance market.

''(2) COMMISSION.—The term 'Commission' means the Harmonized Standards Commission established under section 2921.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage consistent with the National Interim Model Rating Rules in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the National Interim Model Rating Rules, and provides with such notice a copy of any insurance policy that it intends

to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the National Interim Model Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in small group health insurance market.

''(5) NAIC MODEL RULES.—The term 'NAIC model rules' means the rating rules provided for in the 1992 Adopted Small Employer Health Insurance Availability Model Act of the National Association of Insurance Commissioners.

''(6) NATIONAL INTERIM MODEL RATING RULES.—The term 'National Interim Model Rating Rules' means the rules promulgated under section 2912(a).

''(7) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(8) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(9) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2912. RATING RULES.

''(a) NATIONAL INTERIM MODEL RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall, through expedited rulemaking procedures, promulgate National Interim Model Rating Rules that shall be applicable to the small group insurance market in certain States until such time as the provisions of subtitle B become effective. Such Model Rules shall apply in States as provided for in this section beginning with the first plan year after the such Rules are promulgated.

''(b) UTILIZATION OF NAIC MODEL RULES.—In promulgating the National Interim Model Rating Rules under subsection (a), the Secretary, except as otherwise provided in this subtitle, shall utilize the NAIC model rules regarding premium rating and premium variation.

''(c) TRANSITION IN CERTAIN STATES.—

''(1) IN GENERAL.—In promulgating the National Interim Model Rating Rules under subsection (a), the Secretary shall have discretion to modify the NAIC model rules in accordance with this subsection to the extent necessary to provide for a graduated transition, of not to exceed 3 years following the promulgation of such National Interim Rules, with respect to the application of such Rules to States.

''(2) INITIAL PREMIUM VARIATION.—

''(A) IN GENERAL.—Under the modified National Interim Model Rating Rules as provided for in paragraph (1), the premium variation provision of subparagraph (C) shall be applicable only with respect to small group policies issued in States which, on the date of enactment of this title, have in place premium rating band requirements that vary by less than 50 percent from the premium variation standards contained in subparagraph (C) with respect to the standards provided for under the NAIC model rules.

''(B) OTHER STATES.—Health insurance coverage offered in a State that, on the date of enactment of this title, has in place premium rating band requirements that vary by more than 50 percent from the premium variation standards contained in subparagraph (C) shall be subject to such graduated transition schedules as may be provided by the Secretary pursuant to paragraph (1).

''(C) AMOUNT OF VARIATION.—The amount of a premium rating variation from the base premium rate due to health conditions of covered individuals under this subparagraph shall not exceed a factor of—

''(i) +/- 25 percent upon the issuance of the policy involved; and

''(ii) +/- 15 percent upon the renewal of the policy.

''(3) OTHER TRANSITIONAL AUTHORITY.—In developing the National Interim Model Rating Rules, the Secretary may also provide for the application of transitional standards in certain States with respect to the following:

''(A) Independent rating classes for old and new business.

''(B) Such additional transition standards as the Secretary may determine necessary for an effective transition.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, in a nonadopting State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle)—

''(A) prohibit an eligible insurer from offering coverage consistent with the National Interim Model Rating Rules in a nonadopting State; or

''(B) discriminate against or among eligible insurers offering health insurance coverage consistent with the National Interim Model Rating Rules in a nonadopting state.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the terms of the small group health insurance coverage issued in the nonadopting State. In no case shall this paragraph, or any other provision of this title, be construed to create a cause of action on behalf of an individual or any other person under State law in connection with a group health plan that is subject to the Employee Retirement Income Security Act of 1974 or health insurance coverage issued in connection with such a plan.

''(4) NONAPPLICATION TO ENFORCE REQUIREMENTS RELATING TO THE NATIONAL RULE.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to provide the insurance department of the State (or other State agency) with the authority to enforce State law requirements relating to the National Interim Model Rating Rules that are not set forth in the terms of the small group health insurance coverage issued in a nonadopting State, in a manner that is consistent with the National Interim Model Rating Rules and that imposes no greater duties or obligations on health insurance issuers than the National Interim Model Rating Rules.

''(5) NONAPPLICATION TO SUBSECTION (A)(2).—Paragraphs (3) and (4) shall not apply with respect to subsection (a)(2).

''(6) NO AFFECT ON PREEMPTION.—In no case shall this subsection be construed to affect the scope of the preemption provided for under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning in the first plan year following the issuance of the final rules by the Secretary under the National Interim Model Rating Rules.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—A health insurance issuer may bring an action in the district courts of the United States for injunctive or other equitable relief against a nonadopting State in connection with the application of a state law that violates this part.

''(c) VIOLATIONS OF SECTION 2913.—In the case of a nonadopting State that is in violation of section 2913(a)(2), a health insurance issuer may bring an action in the district courts of the United States for damages against the nonadopting State and, if the health insurance issuer prevails in such action, the district court shall award the health insurance issuer its reasonable attorneys fees and costs.

''SEC. 2915. SUNSET.

''The National Interim Model Rating Rules shall remain in effect in a non-adopting State until such time as the harmonized national rating rules are promulgated and effective pursuant to part II. Upon such effective date, such harmonized rules shall supersede the National Rules.

''PART II—LOWER COST PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the State Benefit Compendium in its entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer group health insurance coverage consistent with the State Benefit Compendium in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer group health insurance coverage in that State consistent with the State Benefit Compendium, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting

States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the State Benefit Compendium and that adherence to the Compendium is included as a term of such contract.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets.

''(4) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(5) STATE BENEFIT COMPENDIUM.—The term 'State Benefit Compendium' means the Compendium issued under section 2922.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2922. OFFERING LOWER COST PLANS.

''(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of the benefit, service, and provider mandates that are required to be provided by health insurance issuers in at least 45 States as a result of the application of State benefit, service, and provider mandate laws.

''(b) STATE BENEFIT COMPENDIUM.—

''(1) VARIANCE.—Not later than 12 months after the date of enactment of this title, the Secretary shall issue by interim final rule a compendium (to be known as the 'State Benefit Compendium') of harmonized descriptions of the benefit, service, and provider mandates identified under subsection (a). In developing the Compendium, with respect to differences in State mandate laws identified under subsection (a) relating to similar benefits, services, or providers, the Secretary shall review and define the scope and application of such State laws so that a common approach shall be applicable under such Compendium in a uniform manner. In making such determination, the Secretary shall adopt an approach reflective of the approach used by a plurality of the States requiring such benefit, service, or provider mandate.

''(2) EFFECT.—The State Benefit Compendium shall provide that any State benefit, service, and provider mandate law (enacted prior to or after the date of enactment of this title) other than those described in the Compendium shall not be binding on health insurance issuers in an adopting State.

''(3) IMPLEMENTATION.—The effective date of the State Benefit Compendium shall be the later of—

''(A) the date that is 12 months from the date of enactment of this title; or

''(B) such subsequent date on which the interim final rule for the State Benefit Compendium shall be issued.

''(c) NON-ASSOCIATION COVERAGE.—With respect to health insurers selling insurance to small employers (as defined in section 808(a)(10) of the Employee Retirement Income Security Act of 1974), in the event the Secretary fails to issue the State Benefit Compendium within 12 months of the date of enactment of this title, the required scope and application for each benefit or service listed in the List of Required Benefits shall, other than with respect to insurance issued to a Small Business Health Plan, be—

''(1) if the State in which the insurer issues a policy mandates such benefit or service, the scope and application required by such State; or

''(2) if the State in which the insurer issues a policy does not mandate such benefit or service, the scope and application required by such other State that does require such benefit or service in which the greatest number of the insurer's small employer policyholders are located.

''(d) UPDATING OF STATE BENEFIT COMPENDIUM.—Not later than 2 years after the date on which the Compendium is issued under subsection (b)(1), and every 2 years thereafter, the Secretary, applying the same methodology provided for in subsections (a) and (b)(1), in consultation with the National Association of Insurance Commissioners, shall update the Compendium. The Secretary shall issue the updated Compendium by regulation, and such updated Compendium shall be effective upon the first plan year following the issuance of such regulation.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws (whether enacted prior to or after the date of enactment of this title) insofar as such laws relate to benefit, service, or provider mandates in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, in a nonadopting State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as such laws—

''(A) prohibit an eligible insurer from offering coverage consistent with the State Benefit Compendium, as provided for in section 2922(a), in a nonadopting State; or

''(B) discriminate against or among eligible insurers offering or seeking to offer health insurance coverage consistent with the State Benefit Compendium in a nonadopting State.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not apply to any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the terms of the group health insurance coverage issued in a nonadopting State. In no case shall this paragraph, or any other provision of this title, be construed to create a cause of action on behalf of an individual or any other person under State law in connection with a group health plan that is subject to the Employee Retirement Income Security Act of 1974 or health insurance coverage issued in connection with such plan.

''(4) NONAPPLICATION TO ENFORCE REQUIREMENTS RELATING TO THE COMPENDIUM.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to provide the insurance department of the State (or other state agency) authority to enforce State law requirements relating to the State Benefit Compendium that are not set forth in the terms of the group health insurance coverage issued in a nonadopting State, in a manner that is consistent with the State Benefit Compendium and imposes no greater duties or obligations on health insurance issuers than the State Benefit Compendium.

''(5) NONAPPLICATION TO SUBSECTION (A)(2).—Paragraphs (3) and (4) shall not apply with respect to subsection (a)(2).

''(6) NO AFFECT ON PREEMPTION.—In no case shall this subsection be construed to affect the scope of the preemption provided for under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply upon the first plan year following final issuance by the Secretary of the State Benefit Compendium.

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—A health insurance issuer may bring an action in the district courts of the United States for injunctive or other equitable relief against a nonadopting State in connection with the application of a State law that violates this part.

''(c) VIOLATIONS OF SECTION 2923.—In the case of a nonadopting State that is in violation of section 2923(a)(2), a health insurance issuer may bring an action in the district courts of the United States for damages against the nonadopting State and, if the health insurance issuer prevails in such action, the district court shall award the health insurance issuer its reasonable attorneys fees and costs.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE LAWS

SEC. 301. HEALTH INSURANCE REGULATORY HARMONIZATION.

Title XXIX of the Public Health Service Act (as added by section 201) is amended by adding at the end the following:

''Subtitle B—Regulatory Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ACCESS.—The term 'access' means any requirements of State law that regulate the following elements of access:

''(A) Renewability of coverage.

''(B) Guaranteed issuance as provided for in title XXVII.

''(C) Guaranteed issue for individuals not eligible under subparagraph (B).

''(D) High risk pools.

''(E) Pre-existing conditions limitations.

''(2) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer group health insurance coverage in that State consistent with the State Benefit Compendium, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State

pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2932(g)(2) and an affirmation that such standards are a term of the contract.

''(4) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards adopted by the Secretary under section 2932(d).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market.

''(6) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 2 years of the date in which final regulations are issued by the Secretary adopting the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(7) PATIENT PROTECTIONS.—The term 'patient protections' means any requirement of State law that regulate the following elements of patient protections:

''(A) Internal appeals.

''(B) External appeals.

''(C) Direct access to providers.

''(D) Prompt payment of claims.

''(E) Utilization review.

''(F) Marketing standards.

''(8) PLURALITY REQUIREMENT.—The term 'plurality requirement' means the most common substantially similar requirements for elements within each area described in section 2932(b)(1).

''(9) RATING.—The term 'rating' means, at the time of issuance or renewal, requirements of State law the regulate the following elements of rating:

''(A) Limits on the types of variations in rates based on health status.

''(B) Limits on the types of variations in rates based on age and gender.

''(C) Limits on the types of variations in rates based on geography, industry and group size.

''(D) Periods of time during which rates are guaranteed.

''(E) The review and approval of rates.

''(F) The establishment of classes or blocks of business.

''(G) The use of actuarial justifications for rate variations.

''(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(11) SUBSTANTIALLY SIMILAR.—The term 'substantially similar' means a requirement of State law applicable to an element of an area identified in section 2932 that is similar in most material respects. Where the most common State action with respect to an element is to adopt no requirement for an element of an area identified in such section 2932, the plurality requirement shall be deemed to impose no requirements for such element.

''SEC. 2932. HARMONIZED STANDARDS.

''(a) COMMISSION.—

''(1) ESTABLISHMENT.—The Secretary, in consultation with the NAIC, shall establish the Commission on Health Insurance Standards Harmonization (referred to in this subtitle as the 'Commission') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the laws adopted in a plurality of the States.

''(2) COMPOSITION.—The Commission shall be composed of the following individuals to be appointed by the Secretary:

''(A) Two State insurance commissioners, of which one shall be a Democrat and one shall be a Republican, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(B) Two representatives of State government, one of which shall be a governor of a State and one of which shall be a State legislator, and one of which shall be a Democrat and one of which shall be a Republican.

''(C) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(D) Two representatives of health insurers, of which one shall represent insurers that offer coverage in all markets (including individual, small, and large markets), and one shall represent insurers that offer coverage in the small market.

''(E) Two representatives of consumer organizations.

''(F) Two representatives of insurance agents and brokers.

''(G) Two representatives of healthcare providers.

''(H) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(I) One administrator of a qualified high risk pool.

''(3) TERMS.—The members of the Commission shall serve for the duration of the Commission. The Secretary shall fill vacancies in the Commission as needed and in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Commission shall identify and recommend nationally harmonized standards for the small group health insurance market, the individual health insurance market, and the large group health insurance market that relate to the following areas:

''(A) Rating.

''(B) Access to coverage.

''(C) Patient protections.

''(2) RECOMMENDATIONS.—The Commission shall recommend separate harmonized standards with respect to each of the three insurance markets described in paragraph (1) and separate standards for each element of the areas described in subparagraph (A) through (C) of such paragraph within each such market. Notwithstanding the previous sentence, the Commission shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the State Benefit Compendium pursuant to section 2922(a).

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Commission shall develop recommendations to harmonize inconsistent State insurance laws with the laws adopted in a plurality of the States. In carrying out the previous sentence, the Commission shall review all State laws that regulate insurance in each of the insurance markets and areas described in subsection (b)(1) and identify the plurality requirement within each element of such areas. Such plurality requirement shall be the harmonized standard for such area in each such market.

''(2) CONSULTATION.—The Commission shall consult with the National Association of Insurance Commissioners in identifying the plurality requirements for each element within the area and in recommending the harmonized standards.

''(3) REVIEW OF FEDERAL LAWS.—The Commission shall review whether any Federal law imposes a requirement relating to the markets and areas described in subsection (b)(1). In such case, such Federal requirement shall be deemed the plurality requirement and the Commission shall recommend the Federal requirement as the harmonized standard for such elements.

''(d) RECOMMENDATIONS AND ADOPTION BY SECRETARY.—

''(1) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Commission shall recommend to the Secretary the adoption of the harmonized standards identified pursuant to subsection (c).

''(2) REGULATIONS.—Not later than 120 days after receipt of the Commission's recommendations under paragraph (1), the Secretary shall issue final regulations adopting the recommended harmonized standards. If the Secretary finds the recommended standards for an element of an area to be arbitrary and inconsistent with the plurality requirements of this section, the Secretary may issue a unique harmonized standard only for such element through the application of a process similar to the process set forth in subsection (c) and through the issuance of proposed and final regulations.

''(3) EFFECTIVE DATE.—The regulations issued by the Secretary under paragraph (2) shall be effective on the date that is 2 years after the date on which such regulations were issued.

''(e) TERMINATION.—The Commission shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) UPDATED HARMONIZED STANDARDS.—

''(1) IN GENERAL.—Not later than 2 years after the termination of the Commission under subsection (e), and every 2 years thereafter, the Secretary shall update the harmonized standards. Such updated standards shall be adopted in accordance with paragraph (2).

''(2) UPDATING OF STANDARDS.—

''(A) IN GENERAL.—The Secretary shall review all State laws that regulate insurance in each of the markets and elements of areas set forth in subsection (b)(1) and identify whether a plurality of States have adopted substantially similar requirements that differ from the harmonized standards adopted by the Secretary pursuant to subsection (d). In such case, the Secretary shall consider State laws that have been enacted with effective dates that are contingent upon adoption as a harmonized standard by the Secretary. Substantially similar requirements for each element within such area shall be considered to be an updated harmonized standard for such an area.

''(B) REPORT.—The Secretary shall request the National Association of Insurance Commissioners to issue a report to the Secretary every 2 years to assist the Secretary in identifying the updated harmonized standards under this paragraph. Nothing in this subparagraph shall be construed to prohibit the Secretary from issuing updated harmonized standards in the absence of such a report.

''(C) REGULATIONS.—The Secretary shall issue regulations adopting updated harmonized standards under this paragraph within 90 days of identifying such standards. Such regulations shall be effective beginning on the date that is 2 years after the date on which such regulations are issued.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards adopted under this section on the Internet website of the Department of Health and Human Services.

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards adopted under this section, which may be

used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 2 years after the issuance by the Secretary of final regulations adopting harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards adopted under this subtitle shall supersede any and all State laws (whether enacted prior to or after the date of enactment of this title) insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering coverage consistent with the harmonized standards in the nonadopting State; or

''(B) discriminate against or among eligible insurers offering or seeking to offer health insurance coverage consistent with the harmonized standards in the nonadopting State.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not apply to any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the terms of the health insurance coverage issued in a nonadopting State. In no case shall this paragraph, or any other provision of this subtitle, be construed to permit a cause of action on behalf of an individual or any other person under State law in connection with a group health plan that is subject to the Employee Retirement Income Security Act of 1974 or health insurance coverage issued in connection with such plan.

''(4) NONAPPLICATION TO ENFORCE REQUIREMENTS RELATING TO THE COMPENDIUM.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to provide the insurance department of the State (or other state agency) authority to enforce State law requirements relating to the harmonized standards that are not set forth in the terms of the health insurance coverage issued in a nonadopting State, in a manner that is consistent with the harmonized standards and imposes no greater duties or obligations on health insurance issuers than the harmonized standards.

''(5) NONAPPLICATION TO SUBSECTION (A)(2).—Paragraphs (3) and (4) shall not apply with respect to subsection (a)(2).

''(6) NO AFFECT ON PREEMPTION.—In no case shall this subsection be construed to affect the scope of the preemption provided for under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 2 years after the date on which final regulations are issued by the Secretary under this subtitle adopting the harmonized standards.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this subtitle.

''(b) ACTIONS.—A health insurance issuer may bring an action in the district courts of the United States for injunctive or other equitable relief against a nonadopting State in connection with the application of a State law that violates this subtitle.

''(c) VIOLATIONS OF SECTION 2933.—In the case of a nonadopting State that is in violation of section 2933(a)(2), a health insurance issuer may bring an action in the district courts of the United States for damages against the nonadopting State and, if the health insurance issuer prevails in such action, the district court shall award the health insurance issuer its reasonable attorneys fees and costs.

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.''.

Mr. NELSON of Nebraska. Mr. President, I am pleased to join with my good friend, Chairman MIKE ENZI, in introducing the Health Insurance Marketplace Modernization and Affordability Act. This legislation will help bring much-needed relief to small businesses who are struggling to afford health insurance coverage for their employees.

The affordability of health insurance coverage is a major problem facing America's businesses and consumers. According to the Kaiser Family Foundation, health insurance premiums for businesses rose 9.2 percent last year. While health care cost increases have subsided somewhat, premium increases for last year alone were more than 3 times the growth in workers' wages and two-and-a-half times the rate of inflation.

This legislation helps address the problem of rising health care costs. By providing small businesses with more ability to pool and by harmonizing and streamlining insurance regulations, this bill will help reduce the cost of coverage for small businesses. By lowering costs, this bill holds promise in reducing the number of working Americans who lack health insurance coverage. Our legislation will help reduce costs in a balanced and carefully targeted manner while avoiding some of the problems that other proposals have raised.

In contrast to other proposals, such as Association Health Plans (AHP), our bill retains State-based regulation and oversight. State-based oversight and enforcement is critical to protecting consumers. Unlike other AHP bills, associations cannot self insure and be outside of State oversight. As a former insurance director, this issue is critical for my support.

Moreover, the bill maintains a level playing field in the health insurance marketplace by avoiding harmful provisions that would have led to rampant ''cherry-picking'' and adverse selection problems. The bill does not allow association health plans to abide by less comprehensive rules and under minimal oversight by the U.S. Department of Labor—which would allow these plans to attract only young and healthy groups while increasing costs for the vast majority of small businesses and their workers.

I applaud the effort of Senator ENZI and his talented staff and am pleased to introduce the bill. However, I also recognize that is not a perfect solution; nor is it a panacea for all the problems facing our health care system.

I look forward to working with Senator ENZI to assure that the bill preserves comprehensive and high-quality benefits while, at the same time, allowing small businesses to have access to affordable coverage.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 294—EXPRESSING THE SENSE OF THE SENATE ON THE RETENTION OF THE FEDERAL TAX DEDUCTION FOR STATE AND LOCAL TAXES PAID

Mr. SCHUMER (for himself, Mr. LAUTENBERG, Mr. DURBIN, Mrs. CLINTON, Mr. CORZINE, Mr. SALAZAR, Mr. KENNEDY, Mr. LIEBERMAN, Mrs. FEINSTEIN, Mr. DODD, Mr. KERRY, Mr. OBAMA, Mrs. BOXER, Mr. FEINGOLD, Mr. KOHL, and Ms. STABENOW) submitted the following resolution; which was referred to the Committee on Finance:

S. RES. 294

Whereas no American should be unnecessarily or excessively burdened with additional taxes;

Whereas the Federal income tax has grown more complicated and unmanageable over time, imposing burdensome administrative and compliance costs on American taxpayers;

Whereas on January 7, 2005, President George W. Bush created the President's Advisory Panel on Federal Tax Reform (the ''Panel'') via Executive Order 13369;

Whereas the Panel was tasked with providing several options for Federal tax reform that would simplify Federal tax laws, retain progressivity, and promote long-run economic growth and job creation;

Whereas in its final report, released publicly on November 1, 2005, the Panel recommended the complete repeal of the Federal deduction for State and local taxes, as a central component of both the ''Simplified Income Tax Plan'' and the ''Growth and Investment Tax Plan'';

Whereas State and local taxes have been deductible from the Federal income tax since the inception of the Federal income tax in 1913;

Whereas eliminating the deduction for State and local taxes would create a new form of double taxation at a time where efforts are being made to reduce other forms of double taxation, since repeal would require millions of taxpayers to pay Federal taxes on income that is also taxed at the State or local level;

Whereas Congress has recently taken steps to expand, rather than cut back, the State