allowing our small businesses to take advantage of the leverage they could gain by joining larger groups.

The very simple principle behind this legislation, behind the Enzi bill, is to allow small businesses around this country and their employees to be part of a larger group, thereby driving down the cost of their insurance premiums.

Mr. DURBIN. Will the Senator yield for a question?

Mr. THUNE. I will not yield at the moment. We have a few minutes left on our time, and then the Senator from Illinois could use his time to speak.

Mr. DURBIN. Will the Senator yield for a question?

Mr. THUNE. Not at the moment. Thank you, though.

What I would simply say is, the bill offered by the Senator from Illinois and by his colleagues on the other side is, again, legislation that comes at a high cost to the taxpayers: $73 billion over a 10-year period.

So it is important, when we have this debate, that the people in this country who are following the debate have a clear understanding of what the differences are between the approaches that are being offered—the Enzi bill, the bill that is under consideration today, the small business health plans bill, and the bill offered by our colleagues on the other side—the differences in terms of their approach, one being a Government approach, one being a market-based approach, one actually being scored by the Congressional Budget Office as achieving savings for the Federal taxpayer, and one that clearly adds to the costs of the taxpayer by about $73 billion over a 10-year period.

This has been dubbed Health Week because we are debating health care legislation. Small business health plans is one component of that. We also tried, Monday, to get a vote on legislation that would allow for reforms in our medical malpractice system that would, hopefully, again, drive down the cost of covering people in this country. The high cost of medical malpractice insurance is driving OB/GYNs and other specialists and providers out of the profession, driving up the cost of health care in this country.

In fact, the Department of Health and Human Services, a couple years ago, did a study that suggested the cost of defensive medicine and the cost of the medical malpractice system we have in the country today is actually costing the taxpayers, under Medicaid, an additional $22.5 billion a year.

It is important we address these issues. I believe the American people want us to act. More importantly, they want us at least to vote. That is all I am simply saying. For those on the other side who have consistently resisted the enactment of these two pieces of legislation, that is fine. I understand that is part of this process, that we have a very open and free-flowing debate. That is part of the Senate. That is part of our democratic process we have here.

But when all is said and done, let's bring this to a vote so the people of this country, who expect action out of the Senate, at least know where their elected folks stand when it comes to the issue of small business and whether we are going to provide health care for the employees of small businesses across this country and whether we are going to do anything to address what I think is a very important economic issue to a majority of Americans; that is, this ever-rising, increasing cost of health care.

These two pieces of legislation—small business health care plans, S. 1955, offered by Senator ENZI, the chairman of the HELP Committee—and it is a bipartisan bill; it also has Democratic support, although not enough to stop a filibuster—and the medical malpractice reform legislation, which, again, there were two pieces of medical malpractice reform legislation voted on Monday—we were not able to get enough votes to stop a filibuster to invoke cloture—but, there again, I believe both pieces of legislation have majority support in the Senate and, clearly, have majority support in the House of Representatives.

They have already passed there repeatedly. Small businesses health plans have passed eight times in the House of Representatives. Medical malpractice reform has passed five times in the House of Representatives. That legislation has come to the floor of the Senate and has been blocked from receiving an up-and-down vote.

I think it is in the best interest of people across this country who are expecting Congress to act on the issue of health care and the high cost of health care. They want us to come up with solutions that respect and are in the best interest of the American taxpayer. I believe these two pieces of legislation accomplish that objective.

So I hope before this Health Week is over—and even if we have to push this into next week—we at least get a vote on the floor of the Senate that will enable us to take final action on a couple of pieces of legislation that have been lingering around here for way too long and deserve action by the Senate.

With that, Mr. President, I yield back the remainder of my time.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, morning business is closed.

HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY ACT OF 2006

The PRESIDING OFFICER. The Senate will proceed to the consideration of S. 1955, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1955) 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.

The Senate proceeded to consider the bill which had been reported from the Committee on Health, Education, Labor, and Pensions, with an amendment in the nature of a substitute.

(Strike the part shown in black brackets and insert the part shown in italic.)

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.''.]

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; PURPOSE.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

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 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;

''(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; and

''(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) 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 business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan

shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''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 2006.

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

''(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, 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 dependents of individuals described in subparagraph (A).

''(b) 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.

''(c) 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) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; 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 trustees 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), except that small business health plans shall not be subject to paragraphs (1)(A) and (3) of section 2911(b) of the Public Health Service Act; 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 small group 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 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) 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 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

''(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 but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

''(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in each State in which the small business health plans operate.

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''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 the small business health plans operate.

''(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, or

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

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, 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), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(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).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(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.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

(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 subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

(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 12 months 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 6 months 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—MARKET RELIEF

SEC. 201. 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 MODERNIZATION

''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—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''(a) GENERAL DEFINITIONS.—In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted either the Model Small Group Rating Rules or, if applicable to such State, the Transitional Model Small Group Rating Rules, each in their entirety and as the exclusive laws of the State that relate to rating in the small group insurance market.

''(2) 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 insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a 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 Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a 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 Model Small Group 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); 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 Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in subsection (b).

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

''(9) 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).

''(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.

''(b) DEFINITION RELATING TO MODEL SMALL GROUP RATING RULES.—The term 'Model Small Group Rating Rules' means adapted rating rules drawn from the Adopted Small Employer Health Insurance Availability Model Act of 1993 of the National Association of Insurance Commissioners consisting of the following:

''(1) PREMIUM RATES.—Premium rates for health benefit plans to which this title applies shall be subject to the following provisions relating to premiums:

''(A) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

''(B) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under subparagraph (A).

''(C) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(ii) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(D) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(E) USE OF INDUSTRY AS A CASE CHARACTERISTIC.—A small employer carrier may utilize industry as a case characteristic in establishing premium rates, so long as the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15 percent.

''(F) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(G) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(H) RESTRICTED NETWORK PROVISIONS.—For purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain a similar provision if the restriction of benefits to network providers results in substantial differences in claims costs.

''(I) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—The small employer carrier shall not use case characteristics other than age, gender, industry, geographic area, family composition, group size, and participation in wellness programs without prior approval of the applicable State authority.

''(J) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(2) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to paragraph (3), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(A) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(B) The small employer carrier has acquired a class of business from another small employer carrier.

''(C) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(3) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under paragraph (2), excluding those classes of business related to association groups under this title.

''(4) ADDITIONAL GROUPINGS.—The applicable State authority may approve the establishment of additional distinct groupings by small employer carriers upon the submission of an application to the applicable State authority and a finding by the applicable State authority that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

''(5) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(6) SUSPENSION OF THE RULES.—The applicable State authority may suspend, for a specified period, the application of paragraph (1) to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the applicable State authority either that the suspension is reasonable when considering the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

''SEC. 2912. RATING RULES.

''(a) IMPLEMENTATION OF MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the enactment of this title, the Secretary shall promulgate regulations implementing the Model Small Group Rating Rules pursuant to section 2911(b).

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the Model Small Group Rating Rules, the Secretary, in consultation with the NAIC, shall promulgate Transitional Model Small Group Rating Rules in accordance with this subsection, which shall be applicable with respect to certain non-adopting States for a period of not to exceed 5 years from the date of the promulgation of the Model Small Group Rating Rules pursuant to subsection (a). After the expiration of such 5-year period, the transitional model small group rating rules shall expire, and the Model Small Group Rating Rules shall then apply with respect to all non-adopting States pursuant to the provisions of this part.

''(2) PREMIUM VARIATION DURING TRANSITION.—

''(A) TRANSITION STATES.—During the transition period described in paragraph (1), small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by less than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the premium variation provision of section 2911(b)(1) of the Model Small Group Rating Rules and shall instead be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1).

''(B) NON-TRANSITION STATES.—During the transition period described in paragraph (1), and thereafter, small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by more than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1), and instead shall be subject to the Model Small Group Rating Rules effective beginning with the first plan year or calendar year following the promulgation of such Rules, at the election of the eligible insurer.

''(3) TRANSITIONING OF OLD BUSINESS.—In developing the transitional model small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market, promulgate special transition standards and timelines with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the Transitional Model Small Group Rating Rules under paragraph (1), the Secretary shall provide for the application of the Transitional Model Small Group Rating Rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State 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, including with respect to coverage issued to a small employer through a small business health plan, in a 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, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(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 supercede 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 Model Small Group Rating Rules or transitional model small group rating rules.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their 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) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(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 Benefit Choice 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 health insurance coverage in that State consistent with the Benefit Choice Standards, 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 Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

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

''(6) 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).

''(7) 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 AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits,

services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, 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, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(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 supercede 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 Benefit Choice Standards.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS 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—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) 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.

''(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 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 health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), 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 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.

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

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies 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.

''(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. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

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

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

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

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

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed 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 Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

''(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

''(x) Rationale and protocols to be met before a full examination is conducted.

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the Benefit Choice Standards pursuant to section 2922(a).

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

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

''(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

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

''(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

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

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified 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 certified 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 18 months after the certification by the Secretary of 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 certified under this subtitle shall supersede any and all State laws of a non-adopting State 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, including with respect to coverage issued to a small business health plan, 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, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(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 supercede 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 harmonized standards under this subtitle.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''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.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. With the authorization of the majority of the HELP Committee members, I ask that the committee substitute be modified with the changes that are at the desk.

The PRESIDING OFFICER. The substitute is so modified.

The committee amendment in the nature of a substitute, as modified, is as follows:

(Purpose: In the nature of a substitute)

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; PURPOSE.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

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 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;

''(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; and

''(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) 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 business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''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 2006.

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

''(c) TREATMENT OF FRANCHISES.—In the case of a group health plan which is established and maintained by a franchiser for a franchisor or for 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 franchisor were deemed to be the sponsor referred to in section 801(b) and each franchisee were deemed to be a member (of the sponsor) referred to in section 801(b); and

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

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

''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, 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 dependents of individuals described in subparagraph (A).

''(b) 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.

''(c) 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) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; 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 trustees 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, subject to subparagraph (B) and the terms of this title.

''(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 that meets the requirements of this part, 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 small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small 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 small group 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 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) 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 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

''(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 but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

''(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in each State in which the small business health plans operate.

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''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 the small business health plans operate.

''(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, or

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

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, 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), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(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).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(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.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(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 subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

(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 12 months 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 6 months 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 has control over 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—MARKET RELIEF

SEC. 201. 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 MODERNIZATION

''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—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) 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 insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a 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 Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a 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 Model Small Group 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); 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 Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

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

''(9) 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).

''(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) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

''(B) TOTAL VARIATION LIMIT.—The term 'total variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 2912(a)(1)).

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

''(A) COMPOSITE VARIATION LIMIT.—The composite variation limit shall not be less than 3:1.

''(B) TOTAL VARIATION LIMIT.—The total variation limit shall not be less than 5:1.

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

''(2) MODEL SMALL GROUP RATING RULES.—The following apply to an eligible insurer in a non-adopting State:

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

''(iv) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided

for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State 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, including with respect to coverage issued to a small employer through a small business health plan, in a 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, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(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 supercede 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 Model Small Group Rating Rules or transitional model small group rating rules.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their 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) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(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 Benefit Choice 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 health insurance coverage in that State consistent with the Benefit Choice Standards, 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 Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

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

''(6) 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).

''(7) 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 AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

"SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, 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, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(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 supercede 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 Benefit Choice Standards.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO BENEFITS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State mandates regarding covered benefits, services, or categories of providers that would otherwise apply to eligible insurers.

"SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

"SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS 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—Standards Harmonization

"SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) 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.

''(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 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 health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), 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 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.

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

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies 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.

''(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. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

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

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

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

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

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed 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 Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

''(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

''(x) Rationale and protocols to be met before a full examination is conducted.

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the covered benefit, service, or category of provider mandate standards provided for in section 2922.

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

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

''(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

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

''(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

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

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified 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 certified 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 18 months after the certification by the Secretary of 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 certified under this subtitle shall supersede any and all State laws of a non-adopting State 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, including with respect to coverage issued to a small business health plan, 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, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(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 supersede 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 harmonized standards under this subtitle.

''(4) NON-APPLICATION WHERE CONSISTENT WITH MARKET CONDUCT EXAMINATION HARMONIZED STANDARD.—Subsection (a)(1) shall not supersede any State law of a nonadopting State that relates to the harmonized standards issued under section 2932(b)(1)(B) to the extent that the State agency responsible for regulating insurance (or other applicable State agency) exercises its authority under State law consistent with the harmonized standards issued under section 2932(b)(1)(B).

''(5) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(6) PREEMPTION LIMITED TO HARMONIZED STANDARDS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State requirements for form and rate filing, market conduct reviews, prompt payment of claims, or internal reviews that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

AMENDMENT NO. 3886

Mr. FRIST. I send a first-degree amendment to the desk and ask for its consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment No. 3886 to S. 1955, as modified.

Mr. FRIST. I ask unanimous consent that reading of the amendment be with dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the modified amendment add the following:

''This act shall become effective 1 day after enactment.''

Mr. FRIST. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3887 TO AMENDMENT NO. 3886

Mr. FRIST. I send a second-degree amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment numbered 3887 to amendment No. 3886.

Mr. FRIST. I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. Mr. President, I haven't had an opportunity to see the amendment. I want to cooperate, but I would like to have reading of the amendment.

The PRESIDING OFFICER. The clerk will read the amendment.

The assistant legislative clerk read as follows:

In the amendment strike ''1'' day and insert ''2'' days.

Mr. KENNEDY. I have no objection to waiving the reading.

Mr. FRIST. Was that the second-degree amendment?

The PRESIDING OFFICER. The second-degree amendment has been read.

AMENDMENT NO. 3888 TO MOTION TO RECOMMIT

Mr. FRIST. I now move to recommit the bill to the HELP Committee, and I send that motion to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] moves to recommit the bill to the Committee on Health, Education, Labor, and Pensions with instructions to report back forthwith with the following:

(Purpose: In the nature of a substitute)

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; PURPOSE.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

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 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;

''(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; and

''(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) 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 business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''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 2006.

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

''(c) TREATMENT OF FRANCHISES.—In the case of a group health plan which is established and maintained by a franchiser for a franchisor or for 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 franchisor were deemed to be the sponsor referred to in section 801(b) and each franchisee were deemed to be a member (of the sponsor) referred to in section 801(b); and

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

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

''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, 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 dependents of individuals described in subparagraph (A).

''(b) 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.

''(c) 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) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; 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 trustees 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, subject to subparagraph (B) and the terms of this title.

''(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 that meets the requirements of this part, 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 small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small 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 small group 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 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) 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 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

''(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 but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

''(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in each State in which the small business health plans operate.

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''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 the small business health plans operate.

''(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, or

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

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, 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), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(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).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(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.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(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 subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

(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 12 months 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 6 months 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 has control over 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—MARKET RELIEF

SEC. 201. 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 MODERNIZATION

''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—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) 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 insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a 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 Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a 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 Model Small Group 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); 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 Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

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

''(9) 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).

''(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) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

''(B) TOTAL VARIATION LIMIT.—The term 'total variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 2912(a)(1)).

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

''(A) COMPOSITE VARIATION LIMIT.—The composite variation limit shall not be less than 3:1.

''(B) TOTAL VARIATION LIMIT.—The total variation limit shall not be less than 5:1.

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

''(2) MODEL SMALL GROUP RATING RULES.—The following apply to an eligible insurer in a non-adopting State:

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

''(iv) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary

shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State 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, including with respect to coverage issued to a small employer through a small business health plan, in a 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, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(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 supercede 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 Model Small Group Rating Rules or transitional model small group rating rules.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their 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) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(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 Benefit Choice 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 health insurance coverage in that State consistent with the Benefit Choice Standards, 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 Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

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

''(6) 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).

''(7) 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 AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are

covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, 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, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(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 supercede 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 Benefit Choice Standards.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO BENEFITS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State mandates regarding covered benefits, services, or categories of providers that would otherwise apply to eligible insurers.

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS 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—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) 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.

''(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 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 health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), 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 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.

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

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies 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.

''(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. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers

that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

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

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

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

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

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed 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 Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

''(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

''(x) Rationale and protocols to be met before a full examination is conducted.

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the covered benefit, service, or category of provider mandate standards provided for in section 2922.

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

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

''(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

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

''(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan

designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

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

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified 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 certified 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 18 months after the certification by the Secretary of 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 certified under this subtitle shall supersede any and all State laws of a non-adopting State 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, including with respect to coverage issued to a small business health plan, 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, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(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 supersede 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 harmonized standards under this subtitle.

''(4) NON-APPLICATION WHERE CONSISTENT WITH MARKET CONDUCT EXAMINATION HARMONIZED STANDARD.—Subsection (a)(1) shall not supersede any State law of a nonadopting State that relates to the harmonized standards issued under section 2932(b)(1)(B) to the extent that the State agency responsible for regulating insurance (or other applicable State agency) exercises its authority under State law consistent with the harmonized standards issued under section 2932(b)(1)(B).

''(5) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(6) PREEMPTION LIMITED TO HARMONIZED STANDARDS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State requirements for form and rate filing, market conduct reviews, prompt payment of claims, or internal reviews that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months and one day after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

Mr. FRIST. I ask for the yeas and nays on the motion.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3889

Mr. FRIST. I send a first-degree amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment numbered 3889 to the instructions to the motion to recommit.

Mr. FRIST. I ask unanimous consent that reading of the amendment be dispensed with.

Mr. KENNEDY. Mr. President, until I have a chance to see the amendment, I will have to object.

The PRESIDING OFFICER. The clerk will read the amendment.

The assistant legislative clerk read as follows:

In the amendment strike the number ''3'' and insert the number ''4''

Mr. KENNEDY. I withdraw my objection.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3890 TO AMENDMENT NO. 3889

Mr. FRIST. I now send a second-degree amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment numbered 3890 to amendment No. 3889.

Mr. FRIST. I ask unanimous consent that reading of amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the amendment add the following;

''This act shall become effective 3 days after enactment.''

Mr. FRIST. Mr. President, let me summarize or attempt to summarize where we are in terms of what we just did and where we have been. After a 96-to-2 vote on invoking cloture on the motion to proceed, we have now finally proceeded to the small business health plans bill. We are now at a point that we can begin debating the substance of this bill.

Chairman ENZI is here and is ready for relevant amendments to come forward and be debated. He will have more to say on that shortly.

What is clear is that there have been attempts or suggestions that we use this bill as a Christmas tree for all sorts of amendments, as well intended as they might be, but amendments that don't relate to the underlying bill.

Earlier this week, we began to address and tried to address issues surrounding medical liability. We were unable to do so. We have now proceeded to the small business bill, and it is my intention to stay on that bill, with amendments related to the bill. This bill should have strong, bipartisan support. As it plays out, we will see how strong that bipartisan support may be.

Mr. DURBIN. Will the majority leader yield for a question?

Mr. FRIST. Yes.

Mr. DURBIN. I ask the majority leader to clarify something in his remarks. He referred to amendments as ''Christmas tree amendments.'' There is one amendment on this side of the aisle that he supports on stem cell research. If this is Health Care Week, it would seem that this is a related issue. Does the majority leader characterize that amendment as a ''Christmas tree amendment''?

Mr. FRIST. Mr. President, the issue of stem cells is a very important issue. As my colleague knows, I am very committed to addressing that particular issue.

What is very clear to me, as we started discussing health care on Friday of last week—and it is now Wednesday—is that we need to systematically take an issue, one by one, that is important to the American people, that I have clearly laid out, starting with medical liability, and then proceed to another medical liability bill and proceed to small business, without jumping to other important issues. There is a whole range of issues that affect cost, quality, research, and affect people's lives and affect access to health care. But the only way we are going to be able to address those in an intelligent, effective, step-wise way is to take them one at a time, like medical liability. We were unsuccessful there. We are now moving to small business and focusing on that. There will be amendments, and we welcome them. The chairman is here and ready to talk substance on those amendments. Let's dispose of those and stay on small business. Then we will go and look at a whole range of other issues on health care at an appropriate time.

My intention is to go step-wise through this, with relevant amendments. The chairman is willing to address that and address the issue of small business health plans. We have 46 million people out there who are uninsured today. This doesn't solve the problem, but it fits very nicely with allowing the people out there who don't have access to health care today, who work in small businesses, to have for the first time the opportunity to get the reasonable, affordable health care they simply don't have today. There are a million people—if we pass this bill and it is signed by the President—who are uninsured who will have the opportunity to have insurance.

Let me yield to our chairman because I do encourage our Members on both sides of the aisle to come forward so that we can have substantive debate on the small business health insurance issues out there, without trying—because I know the other side wants to address many other issues, as has been expressed over the last several days, which are their priorities that they want to put before small business health reform plans. But we are simply not going to do that.

Mr. KENNEDY. Well, Mr. President, I say with the greatest respect that it is kind of interesting that the majority leader presents a proposal to the Chamber on behalf of the human resources committee—and as we know, under the Senate rules, that is entirely appropriate—and then in the same breath he asks us to recommit the legislation back to the committee, after he has just spoken for the committee, which suggests that there is a parliamentary maneuver, which is now quite apparent to all of us, that we are not going to have the opportunity to even get a debate on small business assistance, because we have on this side of the aisle the Durbin legislation dealing with relief for small business which effectively we are precluded from having an opportunity to offer.

If I understand the last sentence of the leader, he said we are going to have to dispose of this and go this route before we consider any other amendments. As I understand it from our Democratic leader, we could have reduced those to four or five different amendments that deal with the emergency penalties that some 8 million seniors are going to pay on the prescription drug program, the issue of the ability of Medicare to be able to negotiate lower prices, and the stem cell issue, which my friend has commented on, and Senator HARKIN and Senator FEINSTEIN, and I know the Senator from Tennessee understands the full potential of this. But effectively, as I understand it, this is Wednesday at 3 o'clock; we were here Wednesday morning. I have been effectively here since 10 o'clock in the morning, and we have Wednesday and Thursday and a full week where we can deal with these issues.

It just is troubling to many of us, when we went through this whole argument a week or 10 days ago on the immigration issue, where we were listening to those on that side of the aisle say: Let's have some amendments. Now we hear from them that, no, we cannot. We want lots of amendments on that, but we refuse to have amendments on this.

I daresay that the Senate rules permit debate on different amendments. We have a set of rules out there. You can have an amendment in the first or second degree, and you can have ultimate judgments and decisions. I just want to mention at this time that the action that has been taken now by the leader is effectively going to foreclose an opportunity at this time, when we are having our health care debate, to debate either stem cell research or relief for our senior citizens, who will be paying the penalty because of the requirements of the prescription drug program. We will be denied an opportunity to consider reimportation or negotiation for lower prices. Those are effectively issues that I think most Americans can understand. Certainly these are issues which Members of this body are familiar with and not new issues. We have not been able to get an opportunity.

I certainly regret that is the case because I think, with all respect, as the CBO talks about, there are 48 million Americans without health insurance. According to CBO, this is going to help solve it for 600,000, where we have the option with the Durbin proposal to solve it for millions in small business. But we are denied that opportunity. It is difficult for me to follow that kind of rationale, but we are where we are. I regret that judgment and decision, but that is where we are.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I wish to comment a little bit on that. I think there is plenty of blame to go around for any delays that are happening around here. When we are talking about incorporating in this bill, which deals with small business health plans, an opportunity to give small businessmen a chance at negotiating in the market to bring down costs, with an alternative being proposed—when we are being asked to incorporate into this and put all the weight of the stem cell debate or drug reimportation or Medicare Part D on top of this as a full-blown debate, everybody in this body knows that any one of those would easily take up not just a full week but probably 3 weeks because there would be other kinds of motions and parliamentary objections and processes that would drag any one of those out for that time.

The difficulty with being able to debate anything around here is the

length of time as a result of the right to offer any amendments that anybody wants on any topic. So we do make some efforts to try to keep them relevant. If we do cloture, then they are germane. Germane is a much tougher test, but relevant is not any health care idea in the whole world that could be amended and amended and amended and debated and have processes put in against it that would keep us from ever getting to a decision on small business health plans.

So we are trying to stay with small business health plans. I know Senators DURBIN and LINCOLN have an alternate approach. The alternate approach ought to be voted on, but the alternate approach should not be voted on to the exclusion of ever getting to a vote on this. So we don't want to have just one of them vote and one side feel very good because they got a vote for that one and the other side never gets to their vote. We are trying to find a way to make sure there are votes on both sides on the issues and that not just one side is taking the tough votes but that we do something so we can get to a conclusion for small business. Yes, we are trying to focus this on the problems of small business.

I would like to speak a little bit on the managers' amendment that is before us because there are some changes to the bill that I think the other side of the aisle will like. In most respects, this amendment corresponds very closely to the underlying bill reported out of the HELP Committee in March. It enables small businesses to pool together to save costs and increase access. It allows small business health plans and other plans to offer more affordable coverage options. It will also help streamline the current hodgepodge of health insurance regulation. However, the managers' amendment does make a number of new and important changes to the bill, most importantly in the area of premium rating.

Before I address the managers' amendment, I want to first emphasize, as I have throughout this debate, that I am eager to start sorting the amendments my colleagues might want to offer. As we start the amendment process, I look forward to debating all amendments from my colleagues on both sides of the aisle that are relevant—I mean relevant to the goal of more affordable health insurance for small business owners and their employees and their families.

I have reviewed some of the amendments Members have filed and want to offer. There are many that don't have any place on this bill and only serve to obstruct or delay passage of the bill—amendments addressing the energy efficiency of hybrid cars, Medicare benefits, hate crimes, and environmental air standards. They don't have any place on this bill. This bill is about health insurance for small business owners and their families and their employees and their families. I stand ready and willing to debate all relevant amendments to this bill.

For instance, Senator SNOWE will file an amendment on the issue of benefit mandates. Her amendment would ensure that benefits and services which have been mandated by a majority of States would continue to apply to small business health plans and other insurers. I know there is a lot of strong feeling on all sides of this issue, and I look forward to a lively and serious debate on it. I will have more to say about the Snowe amendment later.

For now, I will focus on what we have done in the managers' amendment to address the concerns raised by many Members of this Chamber. The main change we have made is related to how health insurance premiums are priced for small business. Most States do have rating laws. Those laws limit the amount of variation between premiums charged to different small businesses. Some States allow a great variation; some States allow very little variation.

During debate on this bill yesterday, I heard my Democratic colleagues make a number of speeches on this issue. They expressed their concern about how the bill, as reported from our committee, would affect the health insurance market in their States. They expressed concerns about how the rating rules in our bill might affect businesses with older workers or workers who have serious or chronic illnesses. I also heard these concerns in private conversations with a number of my colleagues over the past few weeks. I don't believe everybody should have to pay exactly the same amount for health insurance. Rules like that hurt young families and lower income workers. They get hurt because they get priced out of the affordable health insurance market.

But I have listened to my colleagues. I have also consulted with some of my colleagues on our committee and with Senator NELSON of Nebraska, who coauthored this bill with me. I value his perspective as a former State insurance commissioner. I also reviewed the bill Senators DURBIN and LINCOLN have offered. I have talked with experts in the insurance markets and insurance regulation, and they don't think the bill Senators DURBIN and LINCOLN have offered would create new and affordable options. In fact, some of those experts think that bill would make things worse, not better.

I will speak some other time in more detail on that. I prefer to go in the direction that we know can work. We know small business health plans will work because they worked in the past before the thicket of conflicting State laws made it too cumbersome to offer such plans.

Our committee heard testimony on this last year, but Senator NELSON and I looked at the Durbin-Lincoln bill anyway to see if there were some ideas we could harvest, some ideas we could incorporate.

After talking with Senator NELSON and my colleagues on the committee, we have developed an amendment that should address the concerns of most of my colleagues on the issue of rating.

The managers' amendment would do two things: First, it would permit States to limit the allowable variation in premiums to a much narrower ratio between the highest and the lowest rates as compared to the bill my committee originally reported.

Second, it would allow States to continue to require community rating of the health insurance policies. What that means is that the bill would allow States to prohibit small business health plans or insurance companies from using the health status of a group of workers as a factor in determining the group's premium.

If States want to allow health status as a factor, they can allow it; if they don't, they can disallow it. This means two things: First of all, most States would be unaffected by the new rating threshold of the managers' amendment. As a matter of fact, we estimate the rating provisions would have no impact on approximately 40 States. The vast majority of those States have reasonably competitive markets, although those markets would be even more competitive if we allow for the creation of small business health plans, allowing small business to band together across State lines to increase their leverage and to cut administrative costs. That is a huge factor.

Second, the managers' amendment preserves much of our original intent to create greater affordability for low-wage workers and for younger workers and their families, but it also allows States to retain reasonable limits on what high-risk groups can be charged. The managers' amendment sets a different threshold for allowable variation in premiums.

The new threshold is similar to the model act published by the National Association of Insurance Commissioners and updated in 2000, its most recent model, and it is what Senators DURBIN and LINCOLN used as the basis of their bill.

So under the managers' amendment, the States use community rating and could continue to use community rating. That means these States could still prohibit the use of health status as a rating factor as long as their system is adjusted to the point that it maintains affordability for low-wage workers and young people and families.

Under the managers' amendment, States would also be permitted to limit small business health plans and other insurers from setting rates that vary by more than a 5-to-1 ratio. In other words, the highest rate for a group in a particular insurance pool could not be more than five times the lowest rate. That would ensure that the insurance pool has a better and more stable balance of risks in the pool while ensuring meaningful limits on premiums for higher risk groups. This is an adjusted community rating standard used in the bill authored by Senators DURBIN and LINCOLN.

Again, just like the Durbin-Lincoln bill, the managers' amendment follows the most recent model from the National Association of Insurance Commissioners. The Durbin-Lincoln standard works out to the same 5-to-1 ratio between lowest and highest rating. So I hope my colleagues understand that here is an area where we have tried to strike a compromise, where we tried to work with them.

I should point out that most States don't use community rating. They use what is known as rating bands. These bands allow for a variety of factors to be used in setting premiums, including health status. We will allow States that use rating bands to continue to use rating bands. None of these States would be required to use community rating if they don't want to. They can continue to allow greater premium variation than the 5-to-1 ratio if they choose. It is a very important point.

The managers' amendment allows States to continue the use of two systems for rating health insurance policies. They can use either the community rating or what is known as rating bands. All the managers' amendment asks is that community-rated States follow the model set forth in the Durbin-Lincoln bill. At least if some reasonable variation in premiums is allowed, young families and lower wage workers may be able to find affordable policies. Of course, affordability would be enhanced if their State markets became competitive enough to attract small business health plans. So we are saying in 10 States it may not attract small business health plans.

I know the rating is extremely complex. This is a very difficult issue to talk about. I kind of enjoy it as an accountant. But the bottom line is very simple. First, we need to maintain a minimum level of affordability in how premiums are set across the country. Young families and lower wage workers in certain States deserve access to affordable health insurance and, therefore, affordable health care, and they deserve the ability to join together with other employees as part of a pool of small business workers through the association in their industries.

Ensuring that all the States have competitive health insurance markets will enable small business health plans to create truly national pools so they can maximize the full size of their membership as they negotiate for better benefits and for better prices.

This is a major area of compromise, and I hope my colleagues recognize it. We have taken a major concept from the bill authored by Senators DURBIN and LINCOLN and we have incorporated it in the managers' amendment. We have done this because Senator NELSON and I and the other cosponsors of the bill are working in good faith to find common ground.

While rating is the most significant issue that we revised in the managers' amendment, it is not the only one. For example, the managers' amendment includes several provisions to make it clear that the scope of the bill's preemption of State law is very narrowly tailored to only three areas. Those three areas are rating, as I have already discussed, benefits, to enable small business health plans to offer national benefit packages, and administrative functions, to reduce some unnecessary costs of health insurance regulation.

It has been a key priority for my Democratic cosponsor, Senator BEN NELSON, that State oversight authority be retained to the maximum extent possible. We have a few former State insurance commissioners in the Senate, and I know they share Senator NELSON's opinion on that. There are also a few former attorneys general in the Senate, and I have listened to them. I have also listened to some of our current attorneys general who have voiced their concerns recently.

I mention that some of their concerns refer more to the House-associated health plans bill, and it is important for people to know this is different from that bill.

We have listened and done these appropriate changes. We have added new provisions that make it very clear that this bill does not preempt, affect, or even disrupt traditional State authority regarding consumer protection, plan solvency, and insurance oversight. That stays with the State.

Most importantly, it would be crystal clear that the bill does not limit in any way a consumer's right to petition their State insurance commissioner or the State courts. That is a very important point. I want to repeat that. It should be crystal clear that it does not limit in any way a consumer's right to petition the State insurance commissioner or their State courts.

The managers' amendment before the Senate represents a significant effort to find common ground. It addresses the issue of rating, which is one of the two major concerns that Senator NELSON and I have heard from colleagues. Senator SNOWE's amendment with respect to State-mandated benefits is an attempt to address the other major concern.

So Members who have raised concerns about these two issues ought to see we are willing to work toward a compromise. There should be no reason we can't arrive at a solution over the next couple of days. Small business owners and working families I don't think are going to accept excuses.

The matter at hand is small business health plans. It is not stem cell research, it is not drug importation, and it is not Medicare. The matter at hand is about creating more affordable health insurance options for small business, and it is an issue that I think can be covered this week or a very small part of next week.

As a manager of this bill, I am willing to entertain any germane amendments. With the consent of my colleagues, I will even go further than that. I will consider relevant amendments. But stem cell research is not relevant to this bill. Drug importation is not relevant to this bill. Medicare is not relevant to this bill. What is relevant to this bill is amendments that address the 27 million Americans without health insurance who work for or depend on small businesses.

If my colleagues have amendments like that, Senator NELSON and I are more than willing to discuss them. Let's focus on the matter at hand. Let's take a meaningful step forward to give America's small business owners and working families more affordable health care.

In regard to some of the comments that have been made, as an accountant, I do remind my colleagues that this is not a case of subtraction. This insurance plan is addition. It will be bringing in newly insured people. When you go to the dry cleaners tonight to pick up your laundry, can you look that person in the eye and say: I don't think you deserve health insurance because you might not demand enough for yourself, so I saved you from yourself? Can you look them in the eye and say to the mom and pop running the business down the street from your home: You don't deserve health insurance either; you don't have it now, we're not going to make it more affordable for you; too bad, we had other things we wanted to discuss?

As you go home today, after you leave the Hill, think about the people around you, the regular people—the cab driver, the worker at the dry cleaner, the person in your neighborhood restaurant, all those people you may not notice who really make the world operate. Many of them don't have any insurance. Some may even own a little business just around the corner, be the owners of it, and still not be able to have insurance.

I am not talking about deluxe insurance, I am talking about any insurance. We are not talking about the employees at the big hotel chains or the big chain restaurants. We are not talking about the employees at Wal-Mart. We already said to them: You can form whatever benefits package you want. You don't have to answer to any State. You don't even have to have review or oversight by insurance commissioners. You don't have to meet any State requirements. We already said that to big business, and big business has done that. They haven't left out critical things. They said: Let's see, this is a competitive market. We have to be competitive. We want to have employees. And you know what. I think they included almost everything that has been talked about here. They did it because they wanted to compete.

Small business isn't any different. They need good employees. They want good employees. They know that if they are going to have good employees they have to do as much as they can afford.

Oh, yes, and when they are doing that, they can also pick up some insurance for themselves, and what they do for themselves, they do for their employees. We hear the estimates of how much this will or will not save. I would like to make a couple of comments on that. We have already seen that the big businesses, instead of paying 35 percent in administrative costs—35 percent—remember, each 1 percent of insurance costs drives 200,000 to 300,000 people out of the market. We are talking about 35 percent administrative costs. But those big businesses that we gave permission to do whatever they wanted to, theirs runs about 8 percent. Do you think they would be more competitive than the small businesses? What keeps the small businesses in business is their flexibility and how much less they make.

So I am not talking about deluxe insurance; I am talking about any insurance. Did you know that in several States there is only deluxe insurance? Did you know that in some States there may only be one insurance provider? Others have been driven out of the market. No, it hasn't been the competition that has driven them out; it could be well-meaning legislators wanting to make sure that everybody has everything they need.

There is a lot with our bodies that we ought to be doing on a regular basis. We ought to be taking care of our body like we take care of our car—well, maybe not like we take care of our car. But the way we usually take care of our body is similar to a rental car. We drive it until something goes wrong and then we take it into the shop. But there are regular services that we ought to provide for our own bodies, and we can do that.

The big companies get to do that tax deductible. It would be nice if the small businesses were able to do that tax deductible as well, and we can get into several of those issues later. We do have a plan here. We are willing to make modifications to it. We are willing to take relevant amendments. We do want to be sure that we get a vote on this bill, if we vote on an alternative measure. I think that is fair.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, let me say at the outset that I salute Senator ENZI from Wyoming. He has shown extraordinary leadership and political courage to bring this issue to the floor. The last time we had a serious conversation about health care for American families and businesses was in that one brief shining moment when the Democrats were in control and brought the Patients' Bill of Rights to the floor; otherwise, during the time that I have served in the Senate, we have run away from this issue. I salute Senator ENZI. Although I disagree with his bill, and I will explain why, I admire his political courage and vision to report a bill from his committee and bring the issue to the floor. I have said that before the press, I have said it at home, and I want to say it on the floor on the RECORD. Although we may disagree on approach, I respect him very much for being willing to bring this complex and politically controversial issue to the floor.

I think if you put it up for a vote as to when a week ends in America, we might not reach a consensus. There are some people who would argue: Why, a week ends on Friday night. That is the end of the week. Others say: No, a week ends on Sunday night. But what we have found is that Health Care Week in the Senate ends at 2:30 on Wednesday afternoon because that is when the Republican majority leader came to the floor and filled the tree, which means closed down amendments on the health care debate.

The Republican majority leader felt there were only two issues relevant to health care in America. The first was the issue of medical malpractice and preempting the States that traditionally regulate medical malpractice. For I believe the fourth time, Senator FRIST offered the medical malpractice bills at the beginning of the week, and they failed again, this time failing to even attract a majority of the Senators supporting either bill that he brought. Then the Senator moved to the health care issue before us: small business health insurance. Then the majority leader came today, having given us all of about a day and a half to consider this issue, and said that is the end of the story. No more amendments. We are not going to consider any other health care amendments in the bill before us. We are closing down the Senate when it comes to health care issues.

That is interesting because what the Republicans have done is to close down debate on stem cell research. Senator FRIST came to the floor and said: We don't want Christmas tree amendments. Christmas tree amendments—stem cell research. I don't know if Senator FRIST has been back in his State. I have. They have roundtable discussions about stem cell research. They sit at a table surrounded by men and women who have their hopes pinned on medical research, those who are suffering from juvenile diabetes and the serious problems that come with it—a mother who gets up several times during the course of the night to wake her young daughter and to test her blood to see if she needs insulin, if she needs to eat something; another family with a young man with Lou Gehrig's disease who has reached the point now where he cannot communicate. All he can do is sit in his wheelchair, this young man in his 20s, with tears rolling down his face, as his mother says: Senator, please, please do something about stem cell research. It may not save him, but it may save someone else. Parkinson's disease—to have my colleague and closest friend in Congress, Lane Evans, a young man stricken with Parkinson's, forced to end his congressional career, who had the strength to come to the floor last year in the House and beg for stem cell research and others suffering from Parkinson's and spinal cord injuries. Think of those people whose lives have been compromised and slowed down because of these injuries. All they want is a chance for a vote on stem cell research.

This President has prohibited stem cell research beyond a single line of available stem cells and has virtually closed it down as a Federal undertaking. We have decided, as a matter of Federal policy, that we will not do this research. We have been asking for over a year for a vote on the floor of the Senate on stem cell research. We were heartened when the Senate majority leader, Senator FRIST, came to the floor in July of last year and said: I may be switching my position, he said, but I am going to support stem cell research. It meant so much because we respect him, a heart transplant surgeon, a man with his medical credentials, to break from the President on this issue, on stem cell research and say he would join us in the fight. But how disheartening to hear today as the Senator from Wyoming and the Senator from Tennessee refer to debate on stem cell research as not relevant to health care. Not relevant. It may not be relevant to their lives, but it is relevant to the lives of thousands of Americans.

We in the Senate know what is at stake. If we don't bring this matter up for a vote this week on stem cell research, the chances of seeing the bill before the end of the year are slim to none. When we think of all of the families counting on us to step up for stem cell research, I want to ask you, Mr. President, isn't this worth a fight? Isn't this worth a fight on the floor of the Senate, to make sure that we get a vote this week on stem cell research, for the people who are counting on us, whose lives are compromised and broken because of disease and illness? Isn't this worth a fight in Health Care Week? Obviously, not on the other side of the aisle. They have declared stem cell research not relevant to Health Care Week.

And what else? They have decided that Medicare prescription Part D is not an important part of Health Care Week. Medicare prescription Part D, where some 9 million Americans in 5 days, if they don't sign up for this program, will face a lifetime penalty. Medicare prescription Part D is a program written by pharmaceutical companies and insurance companies, a program which has been one of the worst that has ever been dreamed up on Capitol Hill. When we want to take a few moments to fix some basics and take the penalty off seniors, the Republican leadership says, now, wait a minute. That is not relevant to a Health Care Week debate. Prescription drugs for 9 million seniors, that is not relevant to a health care debate.

Of course, we have heard Senator DORGAN of North Dakota repeatedly

asking for the opportunity to reimport drugs into the United States so that people have a fighting chance to pay for the drugs that keep them alive. He has been stopped by the Bush administration. He has fought for this opportunity to bring this issue to the floor time and again and insists on it this week in Health Care Week, and the Republican leadership has said, affordable prescription drugs coming in from foreign countries is not relevant to Health Care Week.

So, Mr. President, I think you can understand why many of us come to the floor at this point disappointed. First, we were encouraged by Senator ENZI's decision to bring this matter forward, and then when Senator FRIST said we are going to make it not just the Enzi bill, it will be Health Care Week, we finally said: Here is our chance, a chance for all of the people who have been waiting on us and who have been counting on us. Well, that chance was snuffed out at 2:30 this afternoon with Senator FRIST's procedural motion. Health Care Week turned out to be too good to be true.

It is interesting as well when we consider the basic underlying issue of health insurance. Do you know what the two competing issues are on health insurance? It is very basic. I don't have to explain it to my colleagues in the Senate, and I will tell you why. The proposal that I and Senator BLANCHE LINCOLN have brought to the floor of the Senate to make available to every business across America is exactly the same health insurance that Members of Congress have. If it is good enough for Members of Congress, we think it is good enough for American families. But I listen as Senator ENZI and Republicans stand up and talk about what a terrible idea this would be, to offer to every American the same kind of health insurance that Members of Congress and Federal employees have. Well, if it is so bad, I wonder how many of them have decided not to sign up for it themselves. My guess is they have all signed up for it.

Do you know why it is so good? It is not a government plan. It is a plan administered by the Government at less than 1 percent administrative cost that offers private insurance plans to Federal employees and their families, retirees, and Members of Congress. Private insurance offered by the Government. It is so good that it has worked for 40 years.

Now we have the Republicans coming to the floor, Senator ENZI and others, saying what a terrible idea this is, the same health insurance that protects the Senator arguing against it. You have to ask yourself why, if it is so good for us, can't we offer it to American families? Instead, Senator ENZI has come forward with a plan which makes dramatic changes, not to the health insurance we might offer to the uninsured but in reducing protection, reducing coverage, and increasing costs for people who are already insured. If you thought to yourself for a moment, that is an interesting debate on health insurance, but I am not worried about it, I already have my plan, think twice, because the Enzi bill which he brings before us is going to make your health care less valuable, less protection, and more cost. That is the Enzi plan. That is unnecessary and unfair.

Let me tell you what two organizations have to say about Senator ENZI's proposal, his health insurance plan. You might expect I am going to read something that has some political ring to it. Who is this organization that Senator DURBIN is quoting? They must have some political agenda. I would like to quote from a letter, dated May 10—today—from the American Cancer Society. The American Cancer Society is hardly a political organization. How do they describe the Enzi bill before us?

It is our view that the basic construct of this legislation is fatally flawed and therefore, we ask you to oppose it, regardless of the amendment process on the Senate floor. Consumers will be at the risk of losing important cancer-related protections such as guaranteed insurance coverage of colorectal cancer screening and clinical trial participation.

They go on to say:

It is our view that the Enzi bill will not result in increased access to quality care for most people.

That is from the American Cancer Society.

Now let me go to another letter, and you decide whether this is a political organization. It is the American Diabetes Association. The American Diabetes Association believes that:

The proposed approach in the Enzi bill is fundamentally flawed and must be opposed in all forms in order to protect your constituents with diabetes. Any preemption or weakening of State laws is a major threat to the well-being and lives of people with diabetes and should not be acceptable to the Senate.

And listen to these statistics: Every 24 hours, 4,100 people in America are diagnosed with diabetes—4,100 every 24 hours. There are 230 amputations from diabetes every day in America. There are 120 people entering end-stage kidney disease programs, and 55 people go blind every day from diabetes. We lose 613 Americans daily and 225,000 annually due to this epidemic. Diabetes continues to grow by more than 8 percent each year. And listen to this: One in three of our children will be diagnosed with diabetes in their lifetime—one in three of our children will be diagnosed with diabetes in their lifetime.

They go on to say:

. . . we cannot allow for any loss of ground in this battle.

Signed by the chairman of the board and the chief executive officer. They say:

Accordingly, we ask you to stand with us in full opposition to [the Enzi legislation], no matter which cosmetic changes may be proposed on the floor.

This is a stark and clear choice for the Members of the Senate, what we offer to small businesses and Americans presently uninsured: the same quality health insurance that protects our families as Members of Congress have or we offered them a watered down health insurance program that has been rejected by the American Cancer Society, the American Diabetes Association, the American Association of Retired Persons, the AFL/CIO, AMA, the American Nurses Association—I could go on for three pages of health groups in America that reject the Enzi approach because it will reduce coverage.

We know what the problem is. It has been a long time since we have even taken up this issue. During that period of time, we have seen the number of uninsured Americans grow from 37 million in 1993 to 46 million today—46 million uninsured Americans. But this is the wrong medicine. This Enzi bill will put the insurance companies, not the doctors, in charge of health care. People will be worse off, with less protection.

Yesterday, Senator KENNEDY and I went down to a press conference a few blocks from here. A beautiful young lady came up. She was from Cleveland, OH. She brought her guide dog with her and she told the story about how her diabetes, untreated, resulted in her blindness—young, beautiful lady. She said: I didn't have coverage for it in my health insurance, and as a result my life is much different. She said: I almost died. I am lucky to be alive and thankful to be alive. But when you talk about diabetes protection, you are talking about that young woman and others who could be just like her.

Another young woman came to speak to us and told us how she was a young mother, healthy as could be, but tired from raising those three little kids. Somebody suggested to her to get a mammogram. She thought about it because she had a history of breast cancer in her family, but she said to herself: How much is it going to cost?

They said: $250.

She said: We don't have that. I need $250 for my kids.

She said to her husband: Check the health insurance and see if it covers mammograms.

Her husband called her the next day and said: You can get the test the next day for free.

This beautiful young woman went to get a mammogram and learned within 24 hours that she had the earliest stage of breast cancer. They did a lumpectomy. She went through months of chemotherapy.

She said: I lost my hair, but I got through it all and I am here and I am alive and I am safe and I am going to be a mother for these kids for a long time to come.

So when we talk about cancer screening in health insurance, I don't think that is deluxe care. I don't think that is luxury care. I don't think that is going overboard. Whether it is prostate screening, colorectal screening, or

mammograms, that is basic preventive medicine that saves lives and spares suffering and cuts the cost of health care.

Unfortunately, many of those benefits are casualties in the Enzi approach. As I travel around Illinois, health insurance is the No. 1 issue and has been for years for businesses large and small, labor unions, individuals, families, parents whose kids reach the age of 23 and they finally realize: They are not going to be under my policy. How are they going to be covered?

Between 1993 and 2003, annual premiums Americans paid for health insurance in that 10-year period increased by 79 percent. Employer contributions to their employee insurance increased by 90 percent. These premium increases make it tough for businesses to survive and offer health care protection.

Let be me give an example of one family I know, Jim and Carole Britton. They own the Express Personnel Services in my home town of Springfield, IL. They are good folks, good hardworking businesspeople. They have 24 employees. They pay 85 percent of their employees' premiums. They want to keep doing it. They really believe it is the right thing to do.

Like many small business owners they shop for a small business policy every year because premium costs keep going through the roof. They have been forced to raise the deductible to keep premiums manageable. Last year, the deductible doubled from $500 to $1,000. To save money, Jim and Carole offered a health savings account, which many on the other side of the aisle think is the salvation, a health savings account. I won't go into it in detail, but it is a perfect health insurance plan if you are wealthy and never expect to get sick. They offered it. One of their employees decided they would sign up for a health savings account. That employee now regrets the choice because his wife is pregnant and he wishes he had better, real health insurance coverage.

To those who say solving the health insurance problem is too complicated or too expensive, look beyond the obvious. We already have the Federal Employees Health Benefit Program. It has worked for 40 years for every Member of Congress and 8 million Federal workers. Small business owners and their employees deserve nothing less.

I, along with my colleague from Arkansas, Senator BLANCHE LINCOLN, have introduced legislation to give small businesses affordable choices among private health insurance plans and expanded access to coverage. We call it the Small Employers Health Benefits Plan. We presented it to Senator ENZI. It has been a while now, a few months ago, that we said to him: Take a look at it. You know what this plan is all about. You live with it. We all live with it. We love it. It is a wonderful plan that has competition and real choice from private insurance.

We didn't convince him. I am sorry we didn't. Maybe someday we will. We will keep working on it. But let me tell you why we think it is important, why there are many advantages to the Federal employees program model. This chart spells them out.

Nationwide availability. It covers Federal employees from one coast to the other. Young and old, rich and poor, black, white, and brown, healthy and sick, every Federal employee is covered by it.

Consumer choice. There are more than 278 private insurance companies that bid for this Federal employee coverage. For these private insurance companies, they believe this is a good deal, to get in a pool of people this large.

Group purchasing discounts for small employers: In our bill, we create one nationwide purchasing pool of small employers and self-employed people, which means they can fight for premium discounts just like the Federal Government.

Low administrative costs: Do you know what it costs the Government to run the health insurance program for 8 million Federal employees? Less than 1 percent a year. Some of these plans we are talking about that private businesses have to turn to charge 25 to 30 percent administrative costs each year. You wonder why the costs go up? They are making more money, charging for administration. We don't have the administrative overhead. We use private insurance plans already there.

There is strict oversight and regulation in the Federal Employees Health Benefit Program. We know it works. We like it so much that every single one of us is protected by it.

Two economists have examined our proposal, Dr. Len Nichols of the nonpartisan New America Foundation, and Dr. John Gruber, Ph.D, from MIT. They estimate that our bill could save small businesses between 27 percent and 37 percent on health care premium costs every year, just offering to these small businesses the same health insurance deal that Members of Congress and Federal employees currently receive.

That means Jim and Carole, whom I mentioned earlier, currently offering a policy for a family of four that costs $10,000 a year and paying $8,500 of the premium, could save anywhere from $3,000 to $3,100 as employers and $400 to $500 for each employee. That is before any tax credit, which we propose in our bill, for low-wage workers.

Under our plan, premiums would not be government subsidized, but employers will receive an annual tax credit for contributions made on behalf of workers making $25,000 or less per year.

There is a big debate in this town about tax cuts. If you read the morning paper, you may have noticed the chart on the front page of the Washington Post. The new tax cut proposal from the Bush administration, when it comes to capital gains and dividend incomes, is a very generous proposal to a very small group of Americans. Let me tell you what I mean.

If you are making less than $75,000 a year, the Bush tax cut proposal, warmly embraced by the Republican majority in the House and Senate, means about $100 a year in tax breaks. There is that old $100 check they wanted to give you last week for your gas bill. Here it comes again. That is your tax cut if you are making less than $75,000.

But the same Bush Republican tax cut proposal which will come through Congress now gives to those who are making $1 million a year in income almost $42,000 in tax cuts. I don't recall receiving a single letter from a millionaire saying: Would you please give me a tax cut?

They are insistent on it. We must do this. We have to give them a break. But when Senator LINCOLN and I suggest giving a tax cut to a business that offers health insurance to low-income employees: Oh, that is a terrible Federal subsidy. How could you consider doing that?

Senator THUNE from South Dakota came to the floor yesterday and said it was going to cost us $78 billion over 10 years. Today he came and said it would cost $73 billion. We are gaining some ground. But the bottom line is there is no estimate in that range, anywhere near that range. My challenge to my colleagues on both sides of the aisle, if you believe in tax cuts, why wouldn't you believe in tax cuts for small businesses that provide health insurance for their employees? Isn't that closer to the American dream than a $42,000 tax cut for somebody making $1 million a year? I think it is fairly clear. Obviously they don't.

There are more than 26 million Americans making less than $25,000 a year working in small businesses; 12 million, 40 percent of them, have no health insurance. Is it valuable for America that these people who get up and go to work every day in the small shops and small businesses across our country have health insurance.

I go around Illionis and talk to all kinds of different groups—downstate in my home area, small towns, rural areas, the big city of Chicago. Whenever I say to people: Wouldn't it be part of the American dream that every American had health insurance, it never fails to get a round of applause. That is really an aspiration and a dream which many of us share. We can't reach that dream if we insist on giving tax cuts to millionaires who aren't asking for them and don't provide a helping hand to businesses that are doing the right thing, providing health insurance to low-wage employees.

The tax credit we propose would equal 25 percent of the cost to that business for self-only policies, 30 percent for employees who are either married or single with a child, and 25 percent for family policies. So if a family of four working for Jim and Carole in Springfield make less than $25,000 a

year, there would be an additional savings of $1,874 to $2,172.

Under the Durbin-Lincoln bill, private insurance plans would compete to offer insurance to small businesses, just like they do in the Federal employees program. This chart shows the potential savings that come from the current system and what might occur under the Small Employers Health Benefit Program that Senator LINCOLN and I will offer. Currently, many of these businesses, like the one I described, pay 85 percent of insurance costs, so on a $10,000 policy they are paying $8,500.

Look at how it drops for family coverage under the plan we are proposing—to $3,230 for family coverage. It shows the dramatic savings for each business and the opportunity for them to offer real health care.

A lot of people say: Are you talking about a government insurance plan? Let me show you the choices that my wife, Loretta, and I had when it came to health insurance this year as Federal employees and Members of Congress. Look at these plans: There are 13 plans that we had to choose from as Federal employees.

I will tell you what happened to one of my employees. She chose a plan 1 year, didn't like the way they treated her, and when open enrollment came the following September she dropped them and picked up another plan. What a luxury, real competition. You don't treat me right, you don't get my business next year. It is like shopping for a car and having some real choices.

Most small businesses and most Americans have no real choices, so when we come up with this plan, the Federal employees model plan, and those on the other side of the aisle dismiss it as unrealistic, unfair, deluxe, it is exactly the same health insurance coverage they are living with right now.

If it is good enough for us, why isn't it good enough for the rest of America? That is the bottom line.

All Federal employees receive a booklet every year about the choices that are available for coverage. If you want to take an expensive plan, they will take more out of your paycheck. For the basic plan they take less.

I have a lot of young people on my staff. Krista Donahue, my staffer on this issue, gets up and swims every morning. She picks her health plan. She signed up for a very cheap HMO. My wife and I, maybe not in the same physical condition, sign up for more coverage. That is our choice.

That is everyone's choice in the Senate and the House of Representatives and throughout the Federal Government.

What is wrong with giving that choice to America? Senator ENZI's plan does not give that choice to America. This bill we are proposing has been supported by many groups. It isn't just a matter of Senator LINCOLN and I coming together.

Look at some of the groups that have endorsed the Lincoln-Durbin plan, or the Durbin-Lincoln plan, depending on whether you are from Arkansas or Illinois: The American Academy of Family Physicians, the American Academy of Pediatricians, the American Cancer Society, the American Medical Association, the American Osteopathic Association, the American Psychological Association, Consumers Union, Families USA, Federation of American Hospitals, International Chiropractors, March of Dimes, the National Association of Community Health Centers—the list goes on and on.

And the indication is that these men and women and groups that focus their professional lives on health care reject the Enzi approach which offers less coverage and less protection and believe, as I do, that the plan being offered to Federal employees should be offered to businesses across America.

Sadly, the Enzi plan will wipe out benefit requirements.

I will concede that what I am about to say may have changed somewhat in the managers' amendment. To his credit, as Senator ENZI has realized the weaknesses of his legislation, he has added more protection. If I am going to cite something that has been changed in the managers' amendment, I apologize and will stand corrected on the RECORD. But what I am about to read is based on our best knowledge of what was in the Enzi bill. Maybe it has been changed. I want to give the Senator a chance to correct me, if I misread it.

The Enzi bill will wipe out benefit requirements, including diabetes supplies, mental health coverage, cancer screening, maternity coverage, and child immunizations for 84 million Americans. That includes almost 4 million people in the State of Illinois. The number of Americans who will lose benefit protection under the Enzi plan, S. 1955, each one of these ''stick'' pictures represents 1 million Americans who will lose benefit protection. These are not people who currently have no health insurance. These are people who are gathered here and watching this and have health insurance who think they are part of this debate. Surprise. The Enzi bill has brought you into this debate. Your health insurance is about to be reduced in coverage. The things that you thought you had signed up for, the things that you had bargained for as part of your union that you believe were covered in your plan will be reduced. The coverage will be reduced by the Enzi bill.

His belief is, if we can just lower basic health insurance coverage to a lower level, we can say everybody has it. But what good is it to have health insurance if it isn't there when you need it?

That is the point he missed. If we miss the most basic things in terms of protecting Americans and then sit back and fold our arms and say: Well, we took care of that uninsured problem, sure, we took care of it until someone desperately needs health care and can't afford it because their health insurance plan doesn't cover it.

The idea behind Senator ENZI's bill is if you provide less benefits and less coverage and less protection, it should cost less. That is right. It is reasonable. But if the insurance doesn't cover your illness, if you are left exposed to paying for it out of your own packet, what are you going to do?

One of the ladies who came to our press conference yesterday is a perfect illustration. Her husband had bought a health insurance plan that he thought was a good one, one through an association. He even signed up for a chemotherapy rider on the plan because there had been a history of cancer in his family. Guess what happened. Sadly, he developed virulent lung cancer which required a lot of treatment. They went to their health insurance plan, and they said: We are glad we bought that rider.

Then, in the fine print, there was a limitation on how much they would pay. The poor man lived for years and died an agonizing death. His beautiful young wife from California was there yesterday. When he died, she was left with medical bills of $480,000.

Is that deluxe coverage—what we heard earlier—luxury coverage of health insurance? Would you want to find yourself and your family in a situation where you needed cancer therapy to survive and your plan didn't cover it?

Unfortunately, the Enzi bill moves in that direction, and it doesn't have it. All of the benefit cuts result in about 3 percent to 4 percent savings on premium costs. These are not expensive when they are spread across large populations. They are expensive when they are borne by one family. But if there are millions of people being covered, and a small percentage need it, you spread out the cost. That is what insurance is all about. It is a point that is missed in the Enzi legislation. That is not much of a savings—3 or 4 percent—when you are talking about diabetes, maternity coverage.

Maternity coverage. I know a little bit about that, being the father of three. I can tell you that one of the toughest moments in my life was as a law student—I got married in law school. Yes. We used to do that back in the old days. Loretta was pregnant. The baby came along and she had a serious health problem. We had no health insurance. We went to Children's Hospital in Washington. God bless them. They couldn't have treated us better. They finally said after a while: You are not going to be able to afford to pay this, DURBIN. You either sign up for welfare, which you can do because you don't have any income, but get ready to go bankrupt. You won't be able to pay these bills. There is one choice. There is another choice you can consider. You can go to a clinic for people who are uninsured.

Sure enough. I had to leave my law school and cut a class, drive out to

Maryland, pick up my wife and our little baby girl and sit in a clinic for hours to get a doctor in rotation—never knowing who you would see and sure you would never see them again. They would ask you all the same questions. Let's go through the history again. You tell them over and over—you want to give them everything.

That is what life is like when you don't have health insurance.

When it comes to maternity care, you have to be careful. I will tell you why.

Twenty-five years ago when I was an attorney working in the Illinois State Senate, it came to our attention that there was a company selling health insurance in Illinois with maternity benefits, but when you read closely, the maternity benefits did not cover the newborn infant for the first 30 days of life. Do you know what that means? In our case, in my family's situation, a situation just like it, that sick baby dramatically in need of expensive care for the first 30 days wasn't covered. We put a provision in the Illinois State law which said you cannot offer maternity benefits saying you will pay for the delivery of a baby unless you cover that baby from the moment it is born. That is a requirement in law.

It makes sense, doesn't it? It would be wiped out as one of the State requirements under Senator ENZI's approach. You can buy maternity care. You may be on your own the first 30 days. Heaven forbid you are in a situation with a sick child—and I have been there. It is no fun at all. It took us years to pay those medical bills. We were glad to pay them, and they couldn't have been nicer waiting to be paid, but there were a lot of anxious moments when this father sat in that waiting room wondering if he would ever get to see a doctor for his little girl.

There was a study in the New England Journal of Medicine in the years after President Clinton required that the Federal Employees Health Benefits Program cover mental health benefits. I can't go to a town meeting in my State and mention mental health clinic benefits where I don't have the following occur. I can guarantee you that in any large group this will happen: I will say that health insurance ought to cover mental health benefits—and I think it should. Senator Paul Wellstone, that great champion, used to sit in that back row and stand and beg for health care to cover mental health benefits.

If you mention that at a town meeting in my State or any other State, do you know what happens when the meeting ends? Two or three people are going to wait for you. They will want to talk to you privately. It has happened time and again. They say: Senator, we have a teenage son with a serious mental health problem. We don't know where to turn. We can't get health insurance. There is no coverage for him.

Every time you mention mental health, you find that across America there are people in need of mental health benefits.

When it came to mental health benefits, it was one of the first casualties in the Enzi bill. About 42 States currently offer mental health benefits as part of their health insurance. And that State requirement would be wiped away in the Enzi bill.

Is that deluxe coverage? If you have a bipolar teenage son, a schizophrenic daughter, someone suffering from grave depression in your own household, is that deluxe and luxury coverage? I think it is basic. I think it is what we should be about in America: taking away the stigma of mental disease and offer mental health coverage.

We received letters from organizations such as the American Nurses Association—God bless them—the American Cancer Society, AARP, and the American Diabetes Association. They are all opposed to the Enzi watered-down approach.

In a letter to Congress, 41 attorneys general, including my own attorney general, Lisa Madigan, in Illinois, have publicly opposed this bill.

Another way the Bush-Enzi bill would make people worse off is that it sets Federal rules of how insurers can charge people. I will try to explain what I understand Senator ENZI just did.

Right now in America you can charge health insurance premiums based on a number of factors: Are you well? Are you sick? Are you young? Are you old? Where did you live? What is your injury?

You can be charged different health premiums depending on how you answer those questions. The disparity in health insurance premiums between well people and sick people can be 26 times as expensive for sick people as it is for well people.

There are nine States—most of them in New England, except for North Dakota and Oregon—that have community ratings, which means that everybody in the State of Massachusetts represented by my friend, Senator KERRY, is in the same pool, everybody just like the Federal employees pool. So everyone is charged the same premium, young and old, regardless of their medical history. Senator ENZI comes and says: We just want to change this slightly. We want to be able to say that you can charge five times as much for someone who is sick than someone who is well, even in States with community ratings—five times as much.

They tried that in New Hampshire a few years ago, increasing the premiums for sick people. They dropped their coverage, and 21,000 people were dropped. In a year New Hampshire dropped the plan, saying it is not a good idea. It wasn't a good idea in New Hampshire, and it is not a good idea in the Enzi bill.

That is what is being proposed. Let me show you a study. The Lewin Group, a nonpartisan actuarial firm, shows rates would rise dramatically for businesses with a higher number of older Americans or women of childbearing years.

This shows the average premiums for community-rated States, the average cost per contract. You can see this yellow line. What is happening because Senator ENZI is allowing this divergence and differing amounts of premiums to be charged, you can see a dramatic range of increase that could occur in any given State.

So there is no protection on the upside below 5 to 1. There could be a 5-to-1 difference in premiums charged the lowest rated person in the State to the highest rated person. It is a significant difference.

The Lewin study found that small businesses in strictly regulated States are currently paying the average of $7,738 per month for health insurance for their employees. Under the Enzi bill, businesses with a high number of older people or women of childbearing years would see their premiums increase to more than $20,000 a month, while companies that have a disproportionately high number of healthy, young people would see a decrease in their premiums to $3,096 a month.

Finally, the Bush-Enzi bill will not help the self-employed. Self-employed people are the worst off. They are forced to purchase insurance in the individual market which has the least amount of State oversight. The Enzi bill will take away what little protection self-employed people already have in benefit mandates, which means if you are on your own—you own your little business and looking for health insurance, and you at least know when you are offered a policy it has to provide the basic coverage that your State requires—Senator ENZI wipes that away. It will not give self-employed people a way to pool with larger businesses.

The Enzi bill prohibits self-employed people from being pooled with larger businesses, so they miss out on the discounts of the larger groups. Right now, we believe the realtors who are pushing the Enzi bill ought to step back and take a close look at that provision and ask themselves what percentage of the membership of realtors across America is self-employed. The coverage and protection is not there for you. This may sound good for their members until they take a look at the policy and there is no protection.

Individuals would be pooled with other individuals, so they may save on marketing costs, but they will be priced the same way they are today: individually. Under the Enzi bill, self-employed people can still be denied coverage if their State law permits it, and they can be charged exorbitant rates based on their health status, gender, age, or industry.

Diane Ladley of Aurora, IL, is self-employed and has a chronic condition called fibromyalgia, which causes

chronic pain and fatigue. She has been denied insurance in the individual market. She is currently cutting her pills in half because she cannot afford them.

The Bush-Enzi bill will do nothing to help Diane. Even if she joins an association health plan, an insurer could deny her coverage. If she is offered coverage, insurers will still be able to exclude her current condition or charge an amount so high she could not afford it.

The Lincoln-Durbin bill would allow Diane to be pooled with other small businesses in one national pool. She would have access to the same negotiated discounts as all other small businesses in the pool.

We can make health insurance for small businesses more affordable without slashing benefits or charging people who need insurance even higher prices. My bill, with Senator LINCOLN, is an example of how it can be done. It is a reasonable approach.

I will come back to my starting point as I close my remarks because I know there are other Senators in the Senate waiting to speak. This is a matter of simple justice. If Members of the Senate and the House of Representatives take advantage of the Federal Employees Health Benefit Program because they believe it is fair and right for their families, why won't they offer that same opportunity to other Americans who need health insurance? Why should we give ourselves the status of a privileged class when it comes to health insurance? Why should we say that people across America shouldn't have the same protection our wives and our families have? We ought to offer them in good faith an approach that is the same as our own. If this health insurance we use is good enough for Members of Congress, it is good enough for American families.

I yield the floor.

The PRESIDING OFFICER (Mr. COBURN). The Senator from Wyoming.

Mr. ENZI. Mr. President, I would like a chance to answer the 45 minutes of accusations that were made about my bill and also bring up a few things about the Durbin-Lincoln bill that I have not had a chance to talk about yet, but could I inquire how long the Senator from Massachusetts will speak?

Mr. KERRY. Not that long, maybe 15 minutes, something like that. Hard to say entirely.

Mr. ENZI. I almost hate to break the continuity of the debate when we are talking about some very specific things.

Mr. KERRY. I welcome it. It is not often a debate breaks out in the Senate anymore, so I am happy to welcome it. I ask, through the Presiding Officer, how long the Senator from Wyoming might think he would engage in debate?

Mr. ENZI. Probably about as long as it took Senator DURBIN to cover the fallacies and to boost his bill. I ask that I be the next to speaker after the Senator.

Mr. KERRY. I appreciate that. Maybe that will work because I will just add to some of the things the Senator will probably want to answer, and he can take it all in one bundle.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

A unanimous consent has been requested that Senator ENZI speak after the Senator. Without objection, it is so ordered.

Mr. KERRY. I thank the Chair, and I thank my colleague from Wyoming.

I listened carefully, and I hope a lot of other folks did, to the comments of the Senator from Illinois and from other colleagues in the Senate over the course of the last days.

I wish the Senate were engaging in this issue in a serious way that allows Members to debate the merits of individual approaches to small businesses being covered. Regrettably, that is not the choice of our friends on the other side of the aisle. What they have done is come in with a series of amendments, with second-degree amendments, and, in the language of the Senate, filled the legislative tree, which basically means blocked out the ability of Democrats to bring amendments, to have a real choice between plans as to how we approach small businesses. That is point No. 1. That is irrefutable and damaging to the prospects of trying to deal with the health care crisis we face.

Two years ago, when I was traveling the country as a candidate, no matter what State I went to, no matter what town or what size community or what the political definition of that community was, you always felt a profound sense of responsibility was thrown at you by the people you met from all walks of life.

I met people in town meeting halls, in VFW halls, in rope lines at rallies, in visits to factories, in visits to medium-sized businesses, large businesses. A whole bunch of folks would come up and tug at my sleeve, often with tears in their eyes, look at me, and say: Senator, you have to help us on health care. You have to do something to help us be able to afford health care. They would show me a photograph and say: Look, this is my sister, or this is my mom, and they would tell you about a loved one who could not afford the medicine they needed or who lost their health care when a factory shut down or when a business closed or moved overseas. The faces of those people stay with you forever. Their names do, too.

People—many of them Republicans, many of them conservative small businesspeople—were pleading not for a dumbing down of the system, not for an automatic reduction in coverage, but for a way to expand the ability to have the level of coverage they have today and be able to pay for it. They were looking wearily to this city for help.

I met an awful lot of poor folks who obviously do not have any health care, and the numbers are climbing. More importantly, there is a change in the fabric of our society. I met an awful lot of working Americans who are increasingly watching health care costs go up, education costs go up, energy costs go up, and their wages either stay the same or go down. That is not a sustainable equation in our country.

Increasingly, those workers are being pushed out of the middle class into the working poor or downward within the middle class itself. There isn't one of us who has not met a mother of a child who would describe situations in which she would make life choices for that child, about whether to let her kid play football or some other sport—hockey—because she was afraid she could not afford the medical care if her child broke a leg or somehow were injured.

I heard again and again stories from teachers who would tell me about kids who get no preventive care, they do not get routine exams. Schools have cut nurses, so you do not have a nurse in the school now to take care of someone.

I heard instance after instance of kids who had some form of acting-out in the classroom as a consequence of either an earache or some other chronic disorder. Some of them went to the doctor for the first time when they were 9, 10, 12 years old, and it was too late; they discovered they had a permanent hearing impairment as a consequence. I met the head of pediatrics in the State of Washington at an event we did in Seattle for children's health insurance who told me specifically of kids she had examined who had permanent hearing impairment, and now they will be in special needs education because we did not care enough to give them early intervention.

I met a lot of small business owners who would like to be able to provide their employees with health care but cannot afford it and who know the health care costs are so high that they are standing in the way of being able to hire more workers because they do not have the flexibility and the ability to be able to expand the business and try to cover people or pay even a portion of the health care.

In New Hampshire, I met a woman who had breast cancer. I got to know her pretty well. She told me how she had to keep working day after day right through her chemotherapy no matter how sick she felt because she was absolutely terrified of losing her family's health insurance if she did not show up for a day or two.

In Erie, PA, I met a man named Albert Barker who wonders how he is going to pay literally thousands of dollars in medical bills that he cannot afford. And after he suffered a heart attack and he underwent surgery, guess what. His employer just stopped his health coverage because it was too expensive because he had gotten sick. So they cut him off at the moment of need, and he was basically at that time facing bankruptcy as a consequence. His wife said at the time that she was

reduced to hoping and praying that nothing else happened.

In Council Bluffs, IA, I met a woman named Myrtle Walck who at the time did not know what she would do if the price of medicine rose any higher—which it has—and she paid a huge chunk of her Social Security, which was not very big and was her only source of income, her Social Security check, to the drugstore every month just to cover the cost of her two daily prescriptions.

In Jacksonville, FL, Renee Harris, who owns a schoolbus company that was in her family for over 50 years, was forced to sell the company because she could no longer afford to insure her workers and felt compelled to want to be able to do so.

I heard daily about workers' fears of losing coverage because they either could not afford the higher premiums, the deductibles, the copays, or they thought their employers would drop the coverage altogether.

I talked to people who told me what it was like to live knowing they were one medicine bill, one hospital visit away from bankruptcy. That is the real world we are living in today. That is the real world the Senate ought to be debating. All of these problems are in our health care system today. Yet there is so little time devoted in this Congress to finding the common ground, to finding solutions to get something done for those people who want to believe we will do something to help them.

Instead, what do we have? We have a so-called Health Week in the Senate. This is Health Week so that Senators can come to the Senate and give speeches—not legislate but give speeches. We have speech after speech in a stalemate where the whole week is going to go by, and everyone knows what will happen at the end because we are not really legislating because we are not really here to solve problems. The people I have met deserve to have a Congress that insists on a real debate, really getting the job done.

In all the 22 years I have been here, this is one of those peculiarities of a moment in American history where the Senate is about as dysfunctional as it has been in that whole period of time. Serious efforts to try to deal with problems are just not on the table.

What are we going to have? We are going to have one up-or-down vote on a flawed bill with no chance for Democratic amendments. I know the Senator from Wyoming is going to argue it is a good bill—and we will go through some of those details in a minute, et cetera—but what we have been reduced to doing here is spending an awful lot of time trying to stop bad things from happening instead of putting the competent energy of a lot of people who think a lot about these issues, some of whom have extraordinary expertise, into trying to fix them and move toward a positive health care agenda for our Nation.

Right now, we are fighting to fix the devastating changes that have been forced on the Medicaid Program. We need to overturn the rules allowing increased cost sharing that has been imposed on families who cannot afford it. And we need to prevent new rules from tossing out the early periodic screening diagnosis and treatment protections for children on Medicaid.

Who wrote to the Congress and said: ''Kids in America have enough coverage. We ought to cut out early periodic screening''? Every doctor you talk to worth their salt in this country will tell you what we need is more preventive care, wellness. We need to teach wellness in America. We need to be doing preventive care instead of treating people when they finally get sick, at a time when it is far more expensive than if we intervened early.

On diabetes alone, if we had diabetes screening for every person in America, you could probably save $50 billion. You would avoid a lot of amputations. You would avoid a lot of dialysis. And you could treat it in a far less expensive, more easy way. Are we talking about that here?

We also have to fix the Medicare prescription drug debacle and extend that May 15 deadline for signing up without penalties. Why? Because it has been confusing to seniors all across this country. Because the implementation has been exactly what a lot of people predicted. The result is a whole bunch of things that ought to be happening to reduce the cost for seniors are not happening.

A simple thing would be bulk purchasing to negotiate lower prices on prescription drugs. We ought to be simplifying the enrollment procedures. We ought to be making the benefit more comprehensive, by closing the gaps in coverage.

But the bottom line is, it would be a tragedy if all we did was try to stop these bad things from happening, when everybody knows we have a health care system that is increasingly in extremis, a health care system that is in crisis and imploding on itself in many ways.

This bill, I regret to say, because it deregulates in a selective way all of the insurance delivered in the States, is going to create chaos for people as States choose different offerings and the rules go out the window.

I might add, for a group of people who traditionally have come to the floor to defend States rights, they have, in the last years, proven themselves remarkably selective in where and when they want to protect those States rights because State after State across the country has passed a certain standard of health care. Why? Because they know it works. Because they know it reduces costs. Because they know it helps people have greater quality of care and a better quality of life. Instead, this bill is going to open up the opportunity for people to reduce the level of coverage for people.

There are a whole series of real health care initiatives that the Senate ought to be dealing with. I am convinced we can find an ethical way of dealing with the thorny issue—I recognize there are ethical considerations—but we could find, if we wanted to, an ethical way to deal with a host of in vitro embryos who, regrettably, are going to be discarded altogether, thrown out into the garbage and lost, rather than applied to the possibility of saving life. It seems to me there is a way to fully fund, in a limited way, the appropriate research of initiatives at the National Institutes of Health.

We also need to take up real legislation to get at the heart of racial and ethnic health disparities. We need to make it legal to import prescription drugs from Canada. We need to put medical decisions back in the hands of doctors and nurses and patients, not insurance company bureaucrats. We need to address the nursing shortage by fully funding all the programs under the Nurse Reinvestment Act that we fought so hard to enact.

We need mental health parity, which I heard the Senator from Illinois talk about. We need to address our growing childhood obesity problem which is going to increase the cost of health care all across the country. And we definitely need to reauthorize the State Child Health Insurance Program.

But this is Health Week, and we are going to have a Health Week on the floor of the Senate. It is not going to deal with any of those issues. It also avoids giving families and small businesses access to the same private health insurance that Members of Congress give themselves. I heard the Senator from Illinois talk about this.

I raised this all across the country in 2004. What is it about being a representative of the people, elected by the people to come here to represent the interests of the people, that empowers us to abuse that privilege by giving ourselves the best health care in the world, at less expense, with a nice Government match, bigger than what most businesses can afford, and we are not willing to allow that to happen all across the country? What kind of values does that represent for those who run around talking about values?

It seems to me we ought to stand up and make it clear that every single family's health care is as important as any Member's of Congress. We ought to be offering every single person the opportunity to at least buy into it. Why shouldn't they be able to buy into it and get the coverage? Why shouldn't we open up Medicare and let people who are 55 or older buy into Medicare early? That could happen, and a whole bunch of people would get coverage and we would reduce costs to America.

All you have to do is talk to any hospital administrator in America. First of all, they are dipping into their reserves. A lot of them are on the brink of bankruptcy. Many of them get refunded so late and with such difficulty,

it is hard to plan and come up with a business plan for the hospital. Most importantly, none of them can afford the massive investments in technology that would, in and of themselves, reduce the cost of health care and raise the quality of life.

Something like 45,000 to 50,000 to 90,000 people a year die in hospitals because of medical error. And often, that medical error is the result of pain management or pain mismanagement. The VA has a terrific system. I have been in the VA hospitals. I have seen it. Why do they have the system? Because it is the VA. It is a Government health care plan, and the Government made certain they could invest in these pain management computerized systems. The result is, they have reduced the incidence of mistaken pharmaceuticals being taken, people getting the wrong medicine, getting too much, getting it at the wrong time, getting it even when they took it already—all of these kinds of things that happen.

This week, unfortunately, instead of bringing up a bill that would grant real relief to our small businesses, we are considering a bill that 41 attorneys general of the United States have written to say is bad policy and will only exacerbate the problems in States today. Why are we doing that? Attorneys general are looking at the regulatory process. They are looking at the overall ability of a State without regard, in many cases, to the politics of it but to the law and to the implementation of what happens. And 41 attorneys general have written to say this bill is going to exacerbate current troubles. I hope the Senator from Wyoming will address all of the concerns expressed in the letter of the attorneys general of the United States.

We have also seen the numbers. The Kaiser Family Foundation reports that the number of firms offering health benefits has declined from 69 percent in the year 2000 to 60 percent in 2005. Forty-seven percent of firms with fewer than 10 employees offer health insurance, compared to 90 percent of firms with 50 employees or more.

So everybody agrees something ought to be done. The problem is, the plan offered by the Republican leadership today is not going to help the small businesses to be able to gain coverage for their employees, unless, of course, they give up a whole set of things that currently they are covered for and then without regard to what the pricing is going to be for that. It is a wholesale deregulation of insurance markets. And a wholesale deregulation of insurance markets is, in fact, going to put consumers at risk. The studies show the approach we are being offered will, in fact, have a better chance of increasing the numbers of uninsured, rather than offering small businesses a lot of the relief they so desperately need.

The proponents argue prices are going to drop once we get rid of the benefit mandates created and enacted by State legislatures. Well, first of all, that claim, frankly, does not stand up. There are two separate studies that show benefit mandates are estimated to increase health premiums by a small total of about 3 to 5 percent. Juxtaposed against the annual double-digit premium increases that we have been seeing, it is clear a benefit mandate is not at the heart of the problem. If the benefit mandate is only a 3- to 5-percent increase, but we have been seeing double-digit increases over a period of time, something else has happened.

More importantly, why do we have mandates? What happened to the right of a State to make a decision, as Massachusetts has in the last weeks, that they want to make certain every person is going to be covered and to mandate a system by which businesses have agreed and the legislature has agreed they are going to fund it and people are going to be covered?

Now, the people who have often argued about the heavy unfunded mandate hand of the Government—the people who have most objected to the Federal solution for individual States—are now going to come in and literally give this great gift to some small businesses to be able to go out and do whatever they want and take away from States the ability to guarantee a quality of care for their citizens.

Forty-nine States have passed laws mandating that insurers cover mammography services because they are proven to save lives. Twenty-seven States have passed laws requiring cervical cancer screenings because too many women are dying as a result of poor detection. Forty-six States have passed laws requiring diabetes supplies to be covered because 20.8 million Americans are living with this disease and they have a basic need for care.

So the Senate is going to come in and say: Those mandates are not important. You do not have to do that anymore. And companies are going to be able to create this unbelievable morass of different offerings which are going to confuse and, I predict, infuriate the consumers of this country, just the way the prescription drug medicine Part D program has infuriated seniors across the country.

Now, the numbers I cited about cervical cancer and mammograms and screening, those are not just numbers in a report. We have seen, every day in Massachusetts, how those things make a difference.

Kirsten Paragona of Ipswich discovered, in a routine pap test, that she had developed stage 3 cervical cancer. She was 23 years old. And because that pap test was included as a mandatory benefit in her health plan, Kirsten is alive today, with a 2-year-old daughter, instead of living without a reproductive system.

For all those in the Senate who want to talk about a culture of life, that is a culture of life. And that is a culture of life worth fighting for.

And then there is Gracie Bieda Javier of Jamaica Plain. She lost her mother to breast cancer in 1987. Without mandated coverage for treatment, Gracie's mother was unable to afford the service. And now Gracie is dedicated to helping other women avoid her mother's fate. And because Massachusetts now requires mammography and treatment services, Gracie screens and treats more than 800 low-income women a year. That is because it is mandated.

What is going to happen when you open this up to so-called market forces? People who cannot afford it are really going to get hurt. In her own words: ''[Gracie] could not think of a better way to honor [her] mother on Mother's Day than to make sure we maintain these lifesaving mammogram services.''

I think she has it right. It saves lives.

Under this bill, 2.3 million people in Massachusetts alone will lose guaranteed health benefits. So what are we going to do? We are going to go back and tell them: Gee, the Senate, in all of its wisdom, deemed that these things that the State thought were important for you—they are not important for you. And the State does not have to provide them.

Typically, the great thing about a democracy is that if there is a better idea, people get to hear it and they get to perhaps choose it. They get to debate that kind of alternative on the Senate floor and engage in a debate on the merits of each of these approaches. What is so fundamentally frustrating about this week's discussion is that differing approaches are not really allowed to see the light of day except in speeches.

Frankly, there are a lot of ways we could approach the small business issue. Senator SNOWE and I have had hearings in the Small Business Committee. We have worked for a number of years to try to narrow down options on AHPs. A lot of people don't like them because of the mandate issue. We have tried to wrestle with how do you deal with the mandates and still lower costs. There actually is a way to open regional pooling for States and allow a State that doesn't want to lose its mandates to opt out. Why can't we have that discussion on the floor of the Senate? You could create pooling. You could create a regional effort to reduce costs. But you could allow people the right to also choose to hold onto the benefits they want, if they want, and not deprive the States of that option. There were a host of other ideas that we have been working on.

I regret enormously that all of the effort that went into those negotiations and discussions is not going to see the effort of real legislation by voting on those different amendments. We also had hearings which suggested a whole bunch of different ways which we could provide and help small businesses without doing harm to the system. None of that has been incorporated or is going to be incorporated here.

In 2004, I offered America a plan that would provide every single American the same health insurance enjoyed by Members of Congress. Since that time, Senator DURBIN and Senator LINCOLN have taken that idea and turned it into a bill that creates the Small Employers Health Benefits Program which he discussed. I am a sponsor of that. Under that bill, small businesses could join a national pool and could take advantage of the same Federal administrative functions and bargaining power that is enjoyed by 8 million Federal employees across the Nation. Why should we discriminate against them? Those small businesses could have the ability to pool, to come in and negotiate less expensive health care and provide better benefits to their people and do it with the same leverage that the 8 million Federal employees do. Most importantly, it would protect the State mandates that individual States have decided they want to put in.

Republicans argue that that alternative does not provide the savings that small business owners desperately need. The facts tell a different story. We all want savings. We have to reduce the burden of health care on small business. I understand that. That is why Senator SNOWE and I have been working to arrive at a way to do so. But experts predict that premium savings for participating small businesses could reach as high as 50 percent higher in the first 2 years, if it passes. It seems to me there is a way to approach this. If you go with the idea of Senator DURBIN and Senator LINCOLN, we would actually be able to reduce those costs by almost 50 percent.

If this week was actually an effort to provide relief to small businesses, we would be discussing all of the options to provide that relief. I don't think that coming up with a precooked, one-size-fits-all, one-ideology, one-approach, one-party plan is the way to help businesses. It seems to me that what is going to happen is, a lot of our small business owners and about 25 million uninsured Americans who work for them are going to get caught up in this political show of the week. It is obvious there is a partisan disagreement in what is keeping the Senate as divided and as incapable of doing real legislative effort. And that is a shame. It doesn't have to be that way, if we mapped out enough time and actually worked across the aisle to try to find the common ground. This is one of those issues where you have to put the politics aside. That is how you are going to win one for struggling entrepreneurs.

There are a couple of places we ought to be able to find that common ground pretty quickly. First, how about for children in America? The example I gave earlier of a mother who makes a decision about a child not playing a sport or a child who comes up with a permanent impairment is replicated tens of thousands of times over across the country. We have 11 million children who have no health insurance at all. Sure, if they get extremely sick, they will wind up being taken care of in a hospital and somebody will ultimately see them, if it isn't too late. But the fact is, by that early screening and by involving ourselves early in their lives, educators and medical experts tell us that kids who are properly fed, who have good nutritional practices as a consequence of their meeting with doctors and mothers, learning about those kinds of things, do 68 percent better in school and, in fact, reduces the cost in the long run because they begin to learn good health practices as a consequence of that exposure.

Why couldn't we be using Health Week to talk about the most fundamental value of all, which is caring for our children and providing every child in America with health insurance? You would reduce unnecessary hospitalizations by 22 percent, and you would replace expensive critical care and inexpensive preventative care. Obviously, we would do much better in the classroom and much better in families if that were the case. We are the richest Nation on the planet. Yet one in four kids in America goes without immunizations. One in three children with asthma don't get the medicine they need. It is unbelievable to me that there is as much talk about family values as we hear in the political dialog, such as it is in the country, but then you have 11 million children who don't have any health care, and the country is content to let it stand.

You could insure every single child in America for less than it costs to roll back the Bush tax cut for the wealthiest people. That is the choice. Every child in America could be covered with health insurance if people earning more than $1 million a year didn't have to get another tax cut. But Washington chooses the tax break for the few who don't need it instead of health care for the 11 million who need it desperately.

A 2005 Mason-Dixon poll found the following: 82 percent of respondents think that every child in America should be covered by a Federal health program, if their parents can't afford it; 90 percent of voters believe that 11 million uninsured children in America is a serious problem and Congress ought to address it and resolve it; 79 percent agree that it is our moral responsibility to ensure health care for every child and for the Federal Government to invest in such programs.

In addition, the poll found that when voters are presented with a description of Kids First, the specifics of the bill that would provide kids with health care, 75 percent of voters support it and support its passage by a margin of three to one. They have said overwhelmingly that providing health care to kids is more important than providing the next round of the tax cuts and making them permanent.

So Americans know what we need to do. There is no more pressing need than improving health care for our children. That is why nearly 25 national organizations representing over 20 million Americans have endorsed the Kids First proposal. When I first sent an e-mail telling people about the Kids First, within 2 days, over 20,000 parents phoned in with recordings of why the Kids First Health Program is important to their families. Let me share one or two of those with you.

Jennifer from Central Islip, NY, called in and said:

> I have a child who is on medication . . . that costs me $250 or more a month. I have children who can't go to the dentist. You know, it's the worst feeling in the world, as a mother, to know that in order to afford health care, you're not going to be able to afford the home you live in.

Jordan from Reading, PA, called in and said:

> Nalani . . . my 3-year-old . . . was born with cataracts . . . Eventually chances are she will be blind. Unfortunately, times are really hard in my house and we don't have health insurance and I can't afford to give her the surgery that will fix the problem that she has. I just can't imagine growing up knowing that there was a way that you could have helped. But because nobody thought you were important enough and because your parents didn't have enough money for health insurance . . . you went blind.

With calls like this, it is extraordinary to me that Congress continues to offer a blind eye to these cries for help. This program that is being offered, I regret to say, is only going to confound and confuse and make worse the current delivery of health care in America.

I yield the floor.

The PRESIDING OFFICER. Under the previous unanimous consent agreement, the Senator from Wyoming is recognized.

Mr. ENZI. That went a little longer than I anticipated. I have now listened for an hour and 25 minutes to the other side. I ask unanimous consent that our side have that kind of an opportunity.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. I have an office that is kind of interesting. It is Phil Gramm's old office. He retired from the Senate after several years of mentoring a number of us and was a real force around here. Occasionally, when I am sitting in my office, some phrases will come by that he used. I grab them and I put them in a jar. I figure I will never have an opportunity to use them. But I think today I will pick out of the jar again. He said: When the Democrats talk about health care, they want national health care. The ship of health, they do not care who steers it, as long as it wrecks, and we can have national health care. That is a little bit about what we are talking about today, that plus a combination of saying we are not going to let anybody out there have anything unless they can have everything. That would be nice. I would like for the people of this country to have better insurance than we in the Senate have. That would be my dream.

I wish we could give them better insurance than we have.

Before I came to the Senate, I had better insurance than I have now. When the Democrats say that they want to open up the Federal employee health plans to everybody, they want everybody to have the same thing we have, they don't really mean that. They can't really mean that. I am willing to bet that if we were actually opening up that same pool and letting the Federal employee insurance be used by everybody in the country, the Federal employees would say: Whoa, not on my shift. The Federal unions would say: No, not on my shift. That is a closed pool. That isn't open to everybody. If it was open to everybody, it would be a whole different range of costs. And it is subsidized.

The Democratic alternative, S. 2382, is an open, voluntary pool purchasing agreement. That kind of an arrangement has failed nearly everywhere they have been tried. There is no evidence that they would succeed if they tried it now and would succeed where others have not. Many States have tried this. It is with very little success.

It may look like the Federal Employees Health Benefit Plan, but the Federal employees plan is a closed pool that provides premium support to all eligible individuals. The Democratic alternative is an open pool that would provide a tax subsidy to some of the eligible employers. In other words, it would be apples versus oranges.

A tax subsidy? Let's see, would everybody be able to get a tax subsidy for their health? No, you only get a tax subsidy if you buy the Durbin-Lincoln health plan, a one plan fits all for the United States.

Now, there was some discussion about whether it was $78 billion or $73 billion over 10 years. Let me tell you, they have never scored it, so they have no idea what it would cost. That is what some of the separate actuaries have looked at and said it would score. The Enzi-Nelson-Burns bill would reduce costs and increase coverage, and that is according to respected actuaries. No one can say for sure what that Democratic alternative would do—whether it is tens or hundreds of billions over 10 years.

The Durbin-Lincoln proposal eliminates the ability for national plans in that bill to offer uniform benefit packages. Why is that important? The plan I have put forth—the plan that has come out of committee—allows small businesses to work across State lines to form bigger pools so that they can negotiate effectively against the insurance companies. That is where the savings are. We talk about mandates a lot in here, but the savings come from the ability to have a uniform package so that people in adjoining States can all be bargaining for the same package and have a big enough pool to go up against the insurance companies to be sure they get a better price.

The national plan—the Durbin-Lincoln plan—would still have to meet the requirements of each and every State, even down to the specific particulars of each mandate. Did you know that there are currently 1,700 mandates in the United States? Did you know that those mandates are seldom the same from State to State? They may have the same title, but they are not the same. So how do you put together a package where you say you have to do all of them and be able to go across State boundaries to form bigger pools? You cannot. You would have to do 1,700 mandates if you wanted it to be uniform across the United States.

I need to tell you, too, that some of these mandates we are talking about are screenings. We heard about mammography over there. That is very important. I hope women get mammographies. But did you know that in Wyoming, we really emphasize at this time of year—and I will mention it because Mother's Day is coming up, and this is a huge program in Wyoming to encourage people to buy that for their mother for Mother's Day. It works well. People know exactly what they are buying and exactly how much it costs. It isn't one of many mandates that are in the package that they pay for even though they don't use it.

Somebody said that mandates only add 3 to 4 percent to the bill. No. In the State with the minimum amount in mandates, it adds 5 percent, up to Massachusetts, which adds 22 percent in mandates. Now, I am not suggesting that any of those mandates should not be done. The bill I worked on does set up the ability to have a basic plan. Would people necessarily do the basic plan? They can do the basic plan up to whatever they think is responsible coverage for the people in their association. That doesn't mean nothing; it means they can pick.

You get the impression here that if you allow a basic package, everybody in the country is going to jump on the basic package and say: I can really sock it to my employees; I don't have to provide them with anything anymore. That is not America, and that is particularly not small business America. In small business America, they know they need their employees. Of course, as somebody pointed out, sometimes the only employees are mom and pop. They would like to be insured if they could possibly afford it. So we have to find some way for them to be able to afford it. But this notion that just because there is a mandate out there, everybody will use it, and this notion that just because there is a mandate out there, if we don't require it, it will be dropped—you know, we allow big business in this country to do whatever they want. And do you know what. They provide those basic things.

Now, one of the things which has been mentioned is colorectal cancer screening. Again, the facts suggest that health plans cover important tests like this regardless of State mandate, so it is likely that small business health plans would cover them as well.

In 2004, the Government Accountability Office found that 20 States had laws mandating coverage of colorectal cancer screening tests, which are strongly recommended by the U.S. Preventive Services Task Force for people 50 years or older. Now, the GAO then surveyed 19 small employer plans in 10 of the States without laws mandating this coverage—without laws mandating that. This is an opportunity for those small businessmen, if they are the way they are accused of being here, to just drop it for everybody. Now, despite the absence of State mandates to cover colorectal cancer screening, all 19 small employer plans in those 10 States provided the benefit. Can you believe that? If you have been listening to the discussion this week, you would think they would just drop it. They didn't drop it. They said: Our employees are valuable, and we need to do whatever we can afford to to help them.

Now, how do we help them to afford it better? Let's see. If we could join up with all of the other realtors in the United States—incidentally, the realtors are coming to town next week to their regular annual meeting. As I understand it, 9,000 of them will be here next week, coming to a national convention. Oh, how I wish they would have come 1 week earlier. They could have explained their case. But we have a whole bunch of small businesses out there that really think it is important to be able to band together and get a better deal. It works.

Part of the discussion we have heard today has gone off on some other tangents. That is one of the reasons we are talking about relevant amendments. One of them that we went off on is prescription drug Part D and how, by Monday, people need to sign up for a plan. I really appreciate the coverage we have gotten to get that word out to people across America to make that decision this week. Make it this week. Don't have a penalty because you missed the deadline.

Now, for months I have listened to the Democrats say: This is terrible; this is confusing; this doesn't work; we need to do something different; we have to make it simpler for our seniors. Let's see. Let's just have one Federal plan for them to pick from. It sounds like Phil Gramm again, doesn't it? Ship of state wreck so we can have a national opportunity.

Let me tell you what happened. I was really worried about this prescription drug plan. Wyoming has such a small population—less than 500,000—and we keep hoping we will get off that mark. So far, we have never gotten a city big enough to kind of feed on itself and grow. I said that Wyoming just doesn't have any luck attracting businesses for competition, and we probably won't have any luck on prescription drugs, so I wanted to make sure there was an underlying thing that says if nobody is interested in Wyoming, the Federal Government will take care of it. Do you know what. Wyoming got 41 plans—41 of them. Competition works.

Now, that is what causes the confusion the Democrats keep talking about on prescription drugs. They say that there are too many plans out there for people to make a logical choice. That makes it confusing for seniors. If we infuriate them, we can really get them storming. They have done a pretty good job of that.

You know, I did town meetings, and I tried to help them out. Not only were they appreciative, but a whole bunch of people already signed up and were getting far more benefits than they ever dreamed of. I said: How were you able to make such a critical decision all by yourself? They said: There is this 800 number, and all I needed was to know my prescriptions and the dose and whether I want to buy them locally or do them by mail order, and I got a list of four plans that line up, line by line, that I can make a comparison on. So I know exactly what I am buying, what it is going to cost, and I know what it will be in the long run. How difficult is that?

Oh, but the telephone isn't your only opportunity. You can also go online. There is an online spot that will do the math for you, provide this same kind of list for you to make the comparison. I did it for my mom. Quite frankly, a lot of seniors are going to need help from their kids—kids who are young like me—and they will go through the process and find out how it works. There were things I had questions about, and I got ahold of Health and Human Services and got some changes to make it easier. At first, it looked as if you were signing up before you knew what you were buying, but they changed that so you could get the evaluation first.

Did you know that competition brought down the price by 25 percent even before the first person signed up? That is what those 41 companies who were competing did. Yes, the Democrats say: Wait a minute, there is this penalty and there are a whole bunch of people who don't need any drugs now, so they should not have to sign up now. That is not how insurance works. You buy insurance in case something happens to you. This is a Federal program, so we built in a benefit so that if you had something already happen to you, you can still get low-cost insurance.

In Wyoming, there is a package you can buy for $1.87 a month and avoid all penalties. It gives you assurance that you have coverage in a number of areas. And this is something that would only happen on the Federal level, too. If you come up with something that changes your whole drug prescription thing and it goes up dramatically, every November 15 to December 30 you can change plans. You can go to somebody who will provide all of the benefits you need—the cheapest possible plan. Again, you can have Medicare do the math for you.

So one-size-fits-all doesn't bring prices down. Competition brings prices down. I know that the dream of every person is not to have to sit down with every insurance agent and try to work out something or even understand what their package is. That is where the confusion in the Medicare prescription plan comes in—that possibility of having to sit down with 41 different insurance agents. How many evenings will that take you? There has to be simplification. The simplification we provide in the bill I have been talking about is the ability for your association to work across State lines, build a big pool that is competitive, and to be able to sit down and talk to all of those insurance agents so you can come up with the best possible plan for your association and to save administrative costs.

I am not talking about eliminating the mandate to save the 5 percent to 22 percent—although when they are doing those, they don't only use 25 percent of them, so maybe there is some consideration there. I am not worried about that part. That is not where the savings come in. The savings come in being able to negotiate in a competitive way and reduce administrative costs. Right now, a small businessman pays 35 percent in administrative costs. Big companies that do their own plans pay 8 percent. That is a pretty nice savings, especially if every 1 percent in costs brings 200,000 to 300,000 more people into the market. Let's find a way to bring them into the market. So 35 percent minus 8 percent is a 27-percent savings. Multiply that by 200,000 and see how many people it brings into the market.

We have small businessmen out there—22 million of them—who work in small businesses who are uninsured. That is counting the owners and the employees in the small businesses. We have another 5 million who are self-employed who are uninsured. That is 27 million people in whose lives we can make a difference because they can work through their associations to get better prices—not by eliminating mandates. They want those for their employees. They need those for their employees, to keep their employees; otherwise, they move on to bigger companies. Employees are the heart of the business, and small businessmen realize that more than big businessmen.

But there is another reason the Durbin bill won't work. He has taken away the ability of plans to form these uniform benefits on a national basis, like the national Federal employees plans can do.

So there is not going to be this national pooling because they are not going to be allowed to do what our Federal Employees Health Benefits Plan does because there would not be any insurers who would want to offer a national plan without the same freedom from State mandates that exists for national plans under—get this—the national plans under FEHBP, what we are proposing and what is referred to as the Enzi bill. I like to think about it as the small working peoples bill.

This bill would just create 50 State pools, no true national pools, and all of the 50 State pools will have all the other problems we cited. The Enzi-Nelson-Burns bill trusts small business owners to band together to negotiate for good benefits, while the Democratic alternative gives small business no say in the matter.

They say: The Federal Government is right again; we are going to do what the Federal Government does; oh, but we can't do what the Federal Government does or anything like what the Federal Government does, but that is what you have to settle for.

The Democratic alternative will create a new insurance pool that will operate under a different set of rules which creates the same opportunity for cherry-picking which is adverse selection that Democrats claim the House bill creates. You have to look because the Enzi-Nelson-Burns bill solves that. It solves that cherry-picking. It levels the playing field. It doesn't just grab the best customers from the insurance companies and move them over into the health plans. It allows the insurance companies to compete and also to reinsure, but they have to work with a bigger group.

The Democratic alternative sets up a dual Federal-State regulatory structure that would create confusion for consumers and participating insurers. I will probably cover that a little bit more later. I made a lot of notes on points I ought to cover.

There is one very important one. We were talking about childcare a while ago, and everybody considers childcare to be extremely important. We talked about newborn care. I think everybody considers newborn care to be extremely important. When they talk about eliminating mandates, they like to expand that well beyond what the bill ever allows.

There are requirements in States for who are covered persons. This doesn't change that one bit. Newborns who are covered are not touched—not now, not ever, no intention to do that. So if they are covered now, they will be covered then. It is the law.

I have several other people who would like to use a portion of this time that I just reserved a while ago. I yield time to Senator BURNS who has been very patient. I yield Senator BURNS 15 minutes.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BURNS. Mr. President, I thank my friend from Wyoming, a man who lives south of the 45th parallel from our State, for the work he has done on this legislation.

We have been asked a lot of times what drives us on this legislation. I have been on the Small Business Committee now for three terms. We tried to pass an association health plan for the last 12 to 15 years. Even Senator Bumpers, the senior Senator from Arkansas back in those days, worked on a bill, and his own side wouldn't let him complete that exercise.

The landscape has changed a little bit, and the numbers we are getting

now are much larger than they were, say, 10 years ago: 27 million working Americans are uninsured; 63 percent are either self-employed or work for a small business. For small businesses with 10 or fewer employees, 34 percent of those are uninsured. And for firms with 10 to 24 workers, 27 percent of them are uninsured.

Then I looked at my own State and looked at those numbers, and they are compelling numbers. In Montana, 60 percent of small businesses with fewer than 10 employees do not offer health insurance. That is a big number, 60 percent. Incidentally, most employers in Montana are small businesses. They make up the vast majority of our working force. They are people who run small firms that we typically think of as small business, but there is another small business—and some are a little bit bigger and can be defined as a big business—that we tend to overlook, and they are the people who live on farms and ranches across this country. They have the same desire and same needs for insurance coverage.

As I talk to my folks who live in rural Montana, ranch families simply cannot afford health insurance. Those who can, typically carry a high deductible catastrophic policy and then hope they will be able to weather the health care costs should tragedy strike. Consequently, many ranch families must work second jobs, and do, simply to get health insurance benefits.

Furthermore, very few farm and ranch owners provide their farm workers with health insurance. This isn't because they don't wish to provide that coverage. It is because providing such coverage is unaffordable. One ranch family my staff spoke with currently spends $2,000 a month for coverage of their family of four. As expensive as it is, they can't afford to go without the coverage as one of the members was in a ranch accident which confined him to a wheelchair for the rest of his life.

Consequently, these hard-working Americans are forced to rely on already burdened emergency rooms and health clinics. These small hospitals in rural Montana, some of which we define as critical access hospitals, could not have kept their doors open had it not been for a redefinition of critical access hospitals, telemedicine, and the ability for people to afford health insurance. I fear if we do not begin to seriously address this issue of the uninsured, particularly in rural areas, many of these small critical access facilities cannot survive.

I have heard their argument on the other side. Why would they put at peril health care facilities in rural America? And that is what they would be doing should we continue to do nothing. Therefore, the choice we must make this week could not be clearer. Do we prefer to give small business and individual proprietors the ability to offer their employees health benefits, or do we prefer to continue to limit their ability to offer benefits by Government regulations—mandates?

People like to have a choice. They don't want to go to the store and just buy one brand. It is an easy question for me to answer. The farmers and ranchers and small businesses of Montana—and Senator ENZI has almost the same makeup in his State as we have in our State. Agriculture plays a huge role in Wyoming and Montana. In fact, it contributes more to the GDP than any other industry. So it is not fair to those hard-working folks in rural areas to deny them the benefits that large corporations enjoy or unions and, yes, those of us who serve in this Senate. It is incumbent on us to get these business health plans in place, and now.

As we have no doubt heard, one of the major criticisms of the bill is it allows small business health plans to avoid State-enacted insurance mandates. I don't think that is quite accurate. Specifically, some of the loudest critics allege this bill will cut off coverage for mammograms, childhood immunizations, supplies, colorectal cancer screening, and many other procedures. It is not true. It just isn't true. To use a scare tactic does not do much to further the debate on how we should approach this particular problem.

Studies have shown that health care plans cover these and other services regardless of State mandates. Members of the Senate need look no further than their own health benefits package to know this is the case. Federal employee health benefits plans are not subject to State mandates. Yet these plans provide comprehensive coverage for these services and often provide better coverage than would be covered under most State mandates.

I don't like to see small business characterized as this is a way to save money at the expense of their employees. Small businesspeople are closer to their employees. They understand their responsibilities better than anybody in the world of commerce because they are small, they are a family. That is why the owner has to take the same policy as the employee. You wouldn't even have to mandate that.

I can remember I started a small business and it stayed that way. It wasn't planned, but it did. We insured our employees, and yet my wife and I carried no insurance, and we had a growing family at that time. We did it for economic reasons. But we had the responsibility to protect the folks who worked there.

Most plans cover essential services required by State mandates regardless of whether they are mandated. So why? Because it is not only good policy, but it is good business. For instance, plans generally cover breast cancer screenings regardless of State mandates because it is far cheaper than having to pay for a mastectomy. Plans generally cover screenings for colorectal cancer regardless of State mandates because it is far cheaper to catch it early. Plans cover diabetes treatment regardless of State mandates because it is far less expensive than having to pay for all the maladies that can come about if you are not treated, such as blindness and, yes, amputations.

It is far better to have childhood immunizations in your plan than pay for the more serious diseases that may develop if you are not immunized.

It just makes good sense if you want to keep the employee around and their family that you have grown to know because when you run a small business, it is a personal thing.

We have crafted this approach—and it is not a panacea to cure everything, but at least it is a step in the right direction to cover people who have no insurance today.

It is impossible for small business associations to offer uniform health insurance benefits packages affordably on a regional or national basis. It is hard. If we try to do anything around here, we try to pass legislation that is one size fits all. That is pretty tough to do. Circumstances in Maryland or Virginia are probably a little bit different than they are when you get west of the Mississippi River, especially in my State of Montana.

For instance, what is required for diabetes coverage in Montana is not the same as is required in the States of my friends from Idaho, North Dakota, South Dakota, and Wyoming. Thus, the association that offers benefits to small businesses in this region must adhere to the different mandates in each State. Having to fashion a plan to meet the mandates for each State drives up the cost. What we are trying to do is get our arms around the cost of it. It is impossible to offer a plan without first addressing cost. According to the nonpartisan Congressional Budget Office and the Government Accountability Office, these State-imposed benefit mandates raise the cost of insurance and cause countless Americans to go with no coverage at all.

Moreover, some of those mandates in certain States are for coverage procedures that the vast majority of Americans would not want and probably do not even know are offered. Acupuncture, for example, is a mandated benefit in some States. Some people may benefit from this service, but the vast majority of Americans do not. This is but one example of the hundreds and hundreds of mandates throughout this country for services many do not realize they are covered for and would not avail themselves of if they did. Yet the cost of covering this and other procedures is paid by everyone in that State due to those mandates.

It is a simple thing, insurance. I don't think I have heard it used on the floor since this debate got started. Simply put, when costs go up, coverages go down. It is a simple fact in the underwriting business.

So by allowing the businesses to band together and pool their resources, thereby giving them the same bargaining power large corporations enjoy, this bill, S. 1955, will lower cost

and improve access for millions and millions of Americans who do not have it today. This bill will not create a perfect health plan for all Americans, but that is not what we are talking about. This bill will increase the number of Americans with health insurance. This body can debate endlessly on what the perfect health plan is, but that does little good for the employees of small businesses who currently have none at all. So the choice is clear: Do we increase the amount of working American families with health insurance or do we let partisanship rule the day, as it has for too many years? The American people need better and they deserve better, and this bill will give them better as we move it along.

S. 1955 will lower health costs. All the figures we see tell us that. More importantly, it will give many working Americans affordable health benefits, something they don't have today. My farmers, my ranchers, and the small businesses in small towns across America, which are the backbone of our economy, deserve the same rights as the Fortune 500 companies, unions, and yes, even us, the Government.

It is time to act, even though it may not be perfect. Perfection should never get in the way of doing something for small businesses and their employees.

I thank my friend from Wyoming for allowing me this time.

Mr. CORNYN addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming controls the time.

Mr. ENZI. Mr. President, I thank the Senator from Montana. I thank him for all of the work he went through during the past year as we talked with the insurance companies sitting down with us and the insurance commissioners sitting down with us, trying to work out a plan. I appreciate the efforts of those two groups and all of the associations, and I will talk about those a little bit later.

At this time I yield 15 minutes to the Senator from Texas, Mr. CORNYN.

The PRESIDING OFFICER. The Senator from Texas is recognized for 15 minutes.

Mr. CORNYN. Mr. President, I wish to express my wholehearted support for the bill that the chairman of the HELP Committee, the Health, Education, Labor and Pensions Committee, the Senator from Wyoming, Senator ENZI, has shepherded so far through this process, this small business health plan bill. I think it presents an outstanding opportunity for the Senate to do what my constituents tell me they want every time I go back home and I talk to them, and that is to have access to good quality health care.

The fact is this bill will allow small businesses to band together on a national basis and give them the leverage they need to negotiate good terms with insurance companies for their small businesses and for their employees. This bill would let these insurers bypass some of the mandates that are well-intentioned but which have the impact of driving up the cost of health insurance for employers to the point where many people can't afford it.

In my State we have the unfortunate distinction of having one-quarter of the population without health insurance. What that means is that people end up going to the emergency room for their health care, which has a couple of unintended consequences: No. 1, it costs a whole lot more than it should to treat those conditions in places like a clinic or somewhere else where they could be treated on a nonemergency basis. No. 2, it has the consequence of causing emergency rooms to have to go on divert status, and that is when people come with true emergencies to those emergency rooms and they can't be seen because the emergency rooms are full of people who are going there for nonemergency care. It literally endangers the life and certainly the well-being of that individual who needs to be seen in an emergency room. So we have a broken health care system that can be so inefficient and not serve the best interests of the American people.

What this bill does is provides a means for, as I said, small businesses to band together to increase their negotiating leverage. It is anticipated to be able to bring down the price of health insurance by about 12 percent, which will allow more and more people to gain access to health insurance so they don't have to go to the emergency room, so they have more choices, and so they have the peace of mind that comes with having that coverage in a way that allows them to enjoy the benefits that many of us have but which we take for granted.

We have an alternative that has been offered by Senator DURBIN and Senator LINCOLN, and I think it serves a useful purpose, not because I agree with the alternative proposed, but what it does is it demonstrates the competing approaches or visions or principles between this side of the aisle and that side of the aisle when it comes to providing access to health care.

It has become increasingly apparent to me that while we share the goal of access to good quality health care on both sides of the aisle, we approach it in fundamentally different ways. For example, our side of the aisle—and this bill, I think, reflects the fact that we believe there ought to be something other than a government-run health care system; that private insurance companies offering competitive plans to individuals create consumer choice. It creates competition. And we know that competition creates better service and better prices for American consumers.

The alternative being offered is a command-and-control health care system operated by the Federal Government that is neither efficient nor does it offer the sort of choice and competition, lower price and better service that would be offered through private health insurance options. Indeed, I think our friends on the other side of the aisle have, if nothing else, been consistent in their approach to health care. They believe the Government ought to dictate health care choices for the American people, whether it has to do with CHIPS, the Children's Health Insurance Program, the Medicaid Program, the Medicare Program, or whether it is veterans health care. They believe the Federal Government knows best and that bureaucrats in Washington, DC ought to make the choices that I believe ought to be reserved for me and my family when it comes to what is best for us.

As I said, this is an issue I hear about all the time when I talk to my constituents. It is, in fact, the growing cost of health care and the unavailability of health care that is one of the greatest concerns of my constituents in Texas. Rising costs, systemic inefficiencies, barriers to access, and the increasing costs of coverage represent the challenge we have to confront and which this bill directly addresses.

I understand the difficulties that small businesses have in Texas when trying to obtain quality health care coverage for their employees at reasonable prices. One employee of a small business in Addison, TX, for example, had this to say about the disparity in coverage available to small versus big businesses:

> Our February 2006 renewal premium increased by nearly 40 percent. For a group of 4 insured with no major medical issues and no increases in plan benefits, this was difficult to understand. Our course of action was to look for affordable plans with fewer benefits, but that proved to be difficult and the results undesirable. Fortunately, one of our employees decided to waive coverage and join the policy offered by a large corporation that employs her husband. Her premium under our policy would have been $4,740 a year. The price to carry her on her husband's policy was only $700 a year. Now, that is a disparity. If adequate health coverage is to be provided to employees of small businesses, it is going to be vital that small businesses be allowed to pool their employees in order to maximize their leverage and in order to minimize the premiums to which they are now being subjected.

That is exactly why I support this legislation. Because it would allow associations such as trade, industry, professional, chambers of commerce, for other small business associations to offer fully insured health plans to small businesses. I am a proud cosponsor of this legislation, and I believe this bill is an important step toward making health insurance more available and affordable to more Americans.

I thank Chairman ENZI and his committee for their hard work in bringing this bill to the floor.

The goal of this bill is to reduce health care costs and expand access by creating small business plans. As I mentioned, a recent study indicated that the price of health insurance could literally be brought down as much as 12 percent and as many as an additional 1 million working Americans insured who currently are not insured and have no alternative but to go

to the emergency room for their health care.

Recently, the Small Business Health Plan Coalition sent a letter signed by organizations that represent more than 12 million employers and 80 million workers. They wrote in support of this bill, saying it will:

> Provide workers employed in small businesses and the self-employed with access to Fortune 500-style health benefits now enjoyed by workers in corporate and labor union health plans.

This is a principle that resonates with the American people, and I must say that the American people have every right to be frustrated at Congress's unwillingness to step up and deal with this problem. And woe be it to those politicians who stand between the American people and their desire to see health coverage expanded and access increased. Almost 90 percent of voters, including 93 percent of Republicans and 86 percent of Democrats, in recent polls state that they favor allowing self-employed workers and small business employees to band together to negotiate lower insurance costs.

It is time for the Senate to act. In 2005 alone, health care costs rose three times faster than inflation—and even faster than that for many small businesses. Many small firms had to simply cut benefits or eliminate health care coverage entirely. Only 41 percent of firms with 9 or less employees offer health benefits, compared with 99 percent of larger firms.

We all know that small businesses are our Nation's chief job generator, our No. 1 job creator. They deserve to be treated fairly. But by themselves, these small firms and self-employed people have almost no leverage against insurance companies to try to negotiate fair prices and fair plans.

As it stands now, if they want to join other small employers and purchase insurance through national associations, they have to deal with an enormous array of State-level health insurance regulations and benefit mandates. It goes without saying that many of the mandates that are ordered by State legislators to be included in insurance policies in their States are passed with the best of intentions, but they have the unfortunate effect of raising the price of the insurance to the point where many people simply cannot afford it.

It makes no sense to say that everyone must have a Cadillac with all the bells and whistles when all some people want or can afford is a basic model of a similar vehicle. Big businesses, for the most part, do not have to deal with these regulations. The Congressional Budget Office and Government Accountability Office and others have found that State-imposed benefit mandates raise the cost of health insurance and, in effect, represent an unfunded mandate on employers.

Small business health plans will have a strong incentive to offer the best policies possible for their members. After all, that is what the competitive market is all about. Small businesses will have to compete with large businesses for employees. And when employees decide where they want to go to work, they will look at not only the salary they will be offered but the benefits that will be offered, including the health coverage that is available. This is simply a case of the market working and allowing individuals the maximum freedom to choose what is best for themselves and their families.

In order to remain competitive and attract a talented workforce, I believe small businesses would want to have the ability to offer high-quality health benefits, the same opportunity that large companies currently enjoy. Right now, small businesses effectively have the choice of offering expensive plans with all the required mandates, whether employees will actually even use those services or simply not offering insurance at all. That policy in my State is part of what has been responsible for 25 percent of the people of Texas not having health insurance. It must change.

This is not a complete panacea, but it will provide dramatically better and expanded coverage to the people of my State and the people across this country.

Under the Enzi bill, every small business owner will have the opportunity to choose a comprehensive plan, but they will also have other, more affordable, high-quality choices, too. This will improve access for millions of Americans who currently do not have any insurance at all. I believe this legislation is a good step in the right direction toward increasing the affordability and access to health care that all Americans deserve.

More can certainly be done, and I certainly believe that while this is an important step, we should not stop here. We should continue to increase the number of choices available to the American people—things like consumer-oriented health care, which provides greater transparency and provides information to consumers so they can determine where to go for their health care services based not only on price but based on outcomes—things like health savings plans, which would give people greater access and greater control over their health care decisions and allow them to determine how their health care dollars will be utilized rather than having to buy high-priced plans that contain attributes that they frankly don't need or don't want and which cost them additional money.

Certainly, more could be done, but I urge my colleagues today to support this important legislation because I think it represents a dramatic and long overdue improvement over the status quo.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

(Disturbance in the Visitors' Galleries)

The PRESIDING OFFICER. The Sergeant at Arms will restore order in the gallery.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I do have several things I need to cover. I think I have another speaker or two on their way down. People are talking about being able to offer amendments. They can offer amendments. We want to have discussion, debate; we want to cover objections, answers, proposals on this bill, and we are willing to do anything that is relevant.

There has been a lot of talk about needing to talk about drug reimportation. That is important—at least a 3-week topic. Prescription drugs, that one best wait until after Monday until we see what the exact problem is before we do it. And stem cells, that is probably another 3-week debate.

It took us a year to be able to get this one to the floor so we could talk about small business health plans.

I need to make some comments in regard to a couple of the letters that were read earlier because I am aghast at what was in the letter. The American Cancer Society, as part of that, said: No matter what is done to the Enzi bill, don't vote for it.

That means that should we have an amendment that does everything that is done across the United States for cancer at the present time, they are still urging people to vote against it? It is a little early to say that. It is a little early to say there are not going to be any changes because we will have votes. It may require cloture in order to stay with germane ones instead of the ones that I mentioned and also to make sure—I want to have a vote on the Durbin-Lincoln bill. But I want to have a vote on my bill as well. I think we both ought to have them.

If we release the Durbin-Lincoln one for a vote now, then they can put all kinds of blockages on there so I can't ever get to a vote. And the only vote that we will have had will have been theirs.

We are trying to have some fairness, and so far we have not been able to get to that point.

Another one was the diabetes letter. Again, it said: No matter what you do to the Enzi bill, vote against it. That means, if we instituted every single thing that is being done for diabetes in any State in the Nation, they are still suggesting that they will vote against the bill? Wow. I mean, I have never run into anything such as that.

We looked at the diabetes thing and we said: How do we do this? Because out of the States that do it, there are no two that do it alike, so how do we get these agreements across State lines so they can pool into bigger pools and be able to negotiate against the insurance company so they can bring down rates through negotiation and they can bring down rates by eliminating administrative costs? We are not talking about bringing down rates by eliminating mandates. We are allowing

them to have some flexibility in the mandates so they can come up with a common package, and I am sure that it would include that, just as I did the thing on colorectal cancer. All 19 places that they have been allowed to do that, they included that, even though it wasn't a mandate. They were excluded from that.

I also wanted to put into the RECORD an editorial from the Arkansas Democrat Gazette. It was in the ''Opinion'' section. It says:

Ever face a really tough decision like where to attend college, or whether to take that new job, or should you go with the lasagna or the meatloaf for lunch? So you get out the yellow legal pad and make a list of the pros and cons, right? Well, maybe not for the meatloaf vs. lasagna bit. Some things are a simple gut decision.

But it helps to compare and contrast. And it sure helped to compare and contrast the two bills now floating around the U.S. Senate to make it easier for small businesses to offer health-insurance to their employees. One bill is co-sponsored by Arkansas' senior Senator, Blanche Lincoln.

You could find the comparison on page 2A of Wednesday's paper. There was Senate Bill 1955 (sponsored by Mike Enzi of Wyoming) on one side, and Senate Bill 2510 (Blanche's bill) on the other.

Both sounded fairly similar.

Both promised to make it simpler for businesses to band together and buy cheaper health insurance.

Both promised to save businesses money and cover more folks.

Then we got down to the bottom, to the very latest, biggest question, and, boyohboy, talk about a pro and a con.

The question: What would it cost the Federal Government?

The answers: Nothing for the Enzi Bill.

For the Blanche bill, oh, somewhere in the ritzy neighborhood of between $50 billion and $73 billion over 10 years.

When an estimate for new government spending has a margin of error of some twenty-three billion dollars, you know that new program is just gonna bleed money.

What's worse, or at least as bad, is that Senator Lincoln's bill creates a national health program that'll be under the administration of the federal Office of Personnel Management.

Translation: We the American Taxpayers will be in charge of the care and feeding of yet another bloated bureaucracy.

Why? Why do we need another federal program under federal so-called management adhering not just to federal rules and regs but all the state rules and regs, too? (It gives us a headache just thinking about filling out those insurance forms.)

We suppose it's because some politicians, who may have the best intentions in the world, can't imagine a health plan that doesn't have the government deciding what should and should not be offered at every single bureaucratic level. Thank goodness that isn't required of private employer plans. Can you imagine the red tape? Perish the pencil-pushing thought.

Senator Enzi's proposal, unfortunately entitled the Health Insurance Marketplace Modernization and Affordability Act, takes a freer-market approach. His bill would let small businesses band together and get better deals on health insurance through trade associations.

Now for the devilish detail: Senator Enzi's bill would be regulated by the feds but largely exempt from individual state mandates. The better to offer these plans nationwide and keep costs down.

Remember, the idea is to help small business, not burden them with more state regulations.

Besides, it's nothing new. Major companies like General Motors long have been granted exemptions from state laws regulating insurance—it's called an ERISA exemption, because they have employees all over the country. They couldn't very well insure their employees from sea to shining sea while abiding by every queer detail of every law in every state. Especially when employees move or get transferred and want to keep their insurance.

But won't the absence of state regulations lower standards? Not if the small businesses offering the insurance want to keep their employees. It's in businesses' interest to have good health insurance for their workers, or their workers will go somewhere else. It's how the free market works.

Think of these small-biz health plans like charter schools. They'd be free of, to quote Senator Enzi, ''the current hodgepodge of varying state regulation.'' That way, small businesses across the country can band together and negotiate group health insurance on their terms. Which would be more affordable for the businesses, the employees and, unlike the Blanche bill, the taxpayers.

If we gotta have a federally regulated Small Business Health Plan, we sure don't need one as costly as Blanche Lincoln's. And, yes, we gotta have a Small Business, etc. Because what we've got now isn't working.

Look at the numbers: Of the more than 45 million uninsured Americans, 60 percent are employed by small businesses or are in some way dependent on those businesses. But it's getting harder for a small business to offer health plans because insurance premiums cost so much these days. Since 2000, the cost of health-care premiums for employers has gone up almost 60 percent, including some 11 percent in 2004 alone.

Pass the Enzi Bill and, according to a study by a Milwaukee consulting firm, small businesses would save 12 percent on health insurance premiums. Even more important, some 900,000 uninsured folks would finally get coverage.

Hey, sounds like a plan. Blanche Lincoln's bill, meanwhile, sounds like an expensive, bureaucratic pain in the pocketbook.

Mr. ENZI. I would like to have you see the small business organizations that are supporting the Enzi-Nelson bill. There are a couple of hundred of them here—12 million employers, 80 million workers.

I would like for you to see the small business organizations that are supporting the Durbin-Lincoln bill. Oh, there are two. OK.

I want to share a letter from the National Association of Insurance Commissioners as well. They are writing in response to our May 2 request for a review of S. 2510 Small Employers Health Benefits Program sponsored by Senators DURBIN and LINCOLN.

I ask unanimous consent the letter be printed in the RECORD.

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

MAY 9, 2006.

Hon. MICHAEL B. ENZI,
Chair, Committee on Health, Education, Labor and Pensions, Washington, DC.

DEAR CHAIRMAN ENZI: We are writing in response to your May 2, 2006, request for our review of S. 2510, the Small Employers Health Benefits Program Act, sponsored by Senators Durbin and Lincoln.

The authors of S. 2510 sought the input of the NAIC when drafting their bill and we appreciate their willingness to work with and consider the views of insurance regulators. Like your bill, S. 1955, the Durbin/Lincoln bill does not include the option of self-funded association plans, instead requiring coverage to be purchased from carriers that are licensed in and regulated by the states. This is a significant improvement over association health plan legislation, such as S. 406. The bill would also preserve state rating rules and benefit mandates, thus maintaining state authority over health insurance regulatory policy.

We are concerned, however, about the practical impact this legislation would have. S. 2510 creates an unlevel playing field by requiring plans sold through the Small Employer Health Benefit Plan (SEHBP) to meet different rating standards than those required of plans not sold through the SEHBP. By setting different rules for different carriers, S. 2510 could create an unworkable market in some states.

For example, if state law allows carriers in the general market to charge small employers with healthier, younger workers significantly less, and the federal law requires carriers in the SEHBP to have only a modest variation in rates, the SEHBP carriers will be selected against. In fact, few carriers would want to participate in this program in states with such rating disparity.

S. 2510 does attempt to ameliorate this problem by providing subsidies for those that participate in the SEHBP. We agree that these subsidies will help, but they are not sufficient. We believe that states are best suited to establish rating rules for all carriers—creating two sets of rules would be harmful to the workings of the small group markets. This could also limit the ability of states to develop innovative programs to address the growing health care crisis.

Finally, both S. 2510 and S. 1955 will not affect the underlying and primary causes of skyrocketing health care costs that are making health insurance increasingly unaffordable for millions of Americans. However, we do applaud you and Senators Durbin and Lincoln for your efforts and we hope our dialogue will continue and yield real solutions.

Sincerely,

CATHERINE J. WEATHERFORD,
Executive Vice President and CEO;
ALESSANDRO IUPPA,
Superintendent of Insurance, State of Maine, NAIC President;
WALTER BELL,
Commissioner of Insurance, State of Alabama, NAIC President-Elect.

Mr. ENZI. The experts on S. 2510, the Durbin bill, from the National Association of Insurance Commissioners, write:

S. 2510 creates an unlevel playing field . . . could create an unworkable market in some states. . . . Few carriers would want to participate in this program. . . .

Again, people can read the entire letter, and I am sure they will find that very enlightening. There is a lot more detail there.

Last, I ask unanimous consent to have a letter from the National Association of Health Underwriters printed in the RECORD.

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

MAY 10, 2006.

Hon. MICHAEL B. ENZI,
Chairman, Senate Health, Education, Labor and Pensions Committee, U.S. Senate, Washington, DC.

DEAR CHAIRMAN ENZI: We're very pleased that the Senate will spend this week working on important health issues. The issues to be addressed are critical to the health of America.

One of the most important issues to be addressed this week is health insurance market reform under S. 1955. Our members work on a daily basis out in the real health insurance markets of America. We are in a unique position to be able to observe which markets work better than others and would like to commend everyone who has worked so hard on this legislation to produce an end product that will make health insurance more affordable for small employers. S. 1955. has been modeled to produce a competitive market and a level playing field. Markets with these characteristics are always the strongest and produce the most affordable products.

We are in particular pleased that reform did not go in the direction of S. 2510, Small Employers Health Benefits Program Act of 2006. Under the auspices of creating a more competitive environment, S. 2510 creates the worst kind of unlevel playing field by providing subsidies in the form of reinsurance and a risk corridor only to health plans offered in one purchasing vehicle within the small employer market. It is very important that all plans operating within a special market segment play by the same rules. This ensures the financial integrity of all market players and results in more product availability within that market. S. 2510 does just the opposite. The subsidies it provides are not available to plans that offer coverage in the small employer market outside the purchasing pool and it would provide a significant competitive advantage to carriers operating in the pool, versus those that offer coverage outside the pool. Under this anticompetition model, there would soon be very little choice outside the pool as carriers would be forced to exit a marketing environment where they could not possible operate competitively. This would force more and more people to purchase coverage within the pool, and the cost to government for the subsidies would increase even more.

There is, of course, a reason for the subsidies. Rating rules inside the pool would be considerably more restrictive than they are in the majority of states today, so the pool could not be competitive in many areas without the subsidies. And although the subsidies are for a limited period of time, the unlevel playing field created under this scenario would likely result in no other coverage being available outside the pool for consumers to select once the subsidies to plans operating inside the pool stopped and costs returned to a higher level. And although the subsidies would at that point stop, the rating structure and other mandate provisions inside the pool would continue and the cost of coverage would be predictably high. The ultimate result would be an increased number of people being priced out of coverage and ultimately, more, rather than fewer people would be uninsured.

We do appreciate the positive direction you've taken with S. 1955, and the extreme efforts you've taken to listen to everyone's concerns and respond in a reasonable way. My staff and I look forward to working with you toward achieving enactment of your bill. Please let us know how we can help.

Sincerely,

JANET TRAUTWEIN,
Executive Vice President and CEO.

Mr. ENZI. Again, it is a much more extensive letter. I hope people will take the time to read the RECORD, but it is from the National Association of Health Underwriters. These are the experts on health insurance. They look at this stuff all the time.

It says:

''2510 creates the worst kind of unlevel playing field;'' ''the cost of coverage would be predictably high;'' ''an increased number of people being priced out of coverage;'' and, ''Bottom line: More rather than fewer people would be uninsured.''

That is the National Association of Health Underwriters.

I wish to have some time to go over the good comments, too. But I have been joined on the floor by the majority whip. I will relinquish a few minutes for him to say a few words.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I thank my colleague from Wyoming. I congratulate him for a superb job in crafting this important measure to deal with what many of us think is one of the most pressing problems confronting our country. I have talked to a lot of people in my State, and right up there with gas prices today, they raise the issue of affordability of health insurance.

I have heard from workers who fear that their employer may have to cut back on their coverage. I have met with employers who are concerned that high health care costs prevent them from investing in their businesses and creating new jobs. It would be safe to say I am confident that most if not all of our colleagues have had similar experiences in their own States.

These are real concerns. In every sort of noon-time civic club engagement I have, this is the first thing people bring up. Health premiums have increased nearly three times the rate of inflation, and the percentage of employers offering health care benefits continues to decline.

This is a particular problem for our small employers and entrepreneurs. These are the people who create the majority of the new jobs in our country. Sixty percent of the working uninsured—those Americans who have jobs but don't have health insurance—are either self-employed or they are employed by small businesses.

The sad truth is, it is too darn expensive for many small businesses to provide health coverage to their employees in our country today.

There are a lot of reasons for this.

First, small businesses don't have as much negotiating clout with insurers when they are negotiating premiums as large businesses do. It makes sense. That leaves them stuck, of course, with higher costs.

Also, employees in small firms must absorb a larger share of their plan's administrative costs because there are fewer employees to share those costs.

Third, small businesses must typically purchase care in the uncompetitive, expensive, small group market.

Add all of these factors up and small business health care costs become too expensive for many small businesses to afford.

Small business, as we all know, is the engine that drives the American economy. We must allow them to band together so they can buy health insurance at lower costs so that our people and our economy can keep moving full speed ahead. I commend the HELP Committee for reporting a bill that will do just that.

Finally, I commend Chairman ENZI who has done a magnificent job in moving this legislation forward.

It addresses the unique challenges facing small businesses by allowing them to join together across State lines to offer insurance to their employees. This will give them the needed purchasing power to get a better deal on insurance policies.

Enacting the Health Insurance Marketplace Modernization and Affordability Act will address many of these problems all at once. It will reduce health care premiums. It will increase the number of Americans with insurance. It will reduce the Medicaid rolls. And, most importantly, while doing all of this, the bill will not increase the burden on the taxpayers.

That is not just my opinion; these are the findings of the nonpartisan experts at the Congressional Budget Office. Their cost estimate for S. 1955 shows that the bill will reduce health care premiums in the small group market by 2 to 3 percent. That is important because we know that with every 1-percent change in premiums, 200,000 to 300,000 Americans are able to afford insurance.

So do the math. According to the Congressional Budget Office estimates, 700,000 Americans who would be uninsured under current law—who are currently uninsured—would be covered under the Enzi proposal; 700,000 Americans who would be uninsured under current law, would be insured under Chairman ENZI's proposal.

By helping small businesses expand coverage for their employees, CBO estimates that 135,000 Americans, who without the Enzi bill would be on Medicaid, would now receive private insurance under the Enzi bill. Clearly, this is the way to go.

Most importantly, and unlike the Democrats' alternative, the bill accomplishes this without increasing the burden on the Federal taxpayers. In fact, the Enzi-Nelson bill will save the taxpayers $3 billion over the next 10 years. Nearly 1 million Americans get better health coverage, and the taxpayers will save the $3 billion I referred to over the next 10 years. This legislation is good, strong medicine.

My colleagues across the aisle have called the plight of small business a ''distraction.'' But this situation that affects the economic engine of our country—the small businesses—is a real problem, not a distraction, and the problem is not getting better on its own. It ought to be addressed.

In 4 of the past 5 years, small businesses paid double-digit increases each year in health insurance premiums. At that rate, more and more employers will be forced to scale back or drop coverage altogether for their employees. The Enzi bill is the first step in righting that crisis.

Again, I commend the HELP Committee for reporting the bill that addresses the challenges facing small businesses.

I also note the tremendous contribution made throughout this process by Senator TALENT, who has been a tireless advocate for small business health plans during his tenure in the House and during his 4 years here in the Senate.

This is an important piece of legislation that will address a very significant problem facing many of our small businesses—the high cost of health insurance.

I urge our colleagues to vote to invoke cloture and to support the Enzi bill. It would be an important step in the right direction for Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I thank Senator MCCONNELL. I appreciate all of his effort and help. I appreciate the Senator bringing up Senator TALENT. I need to mention Senator SNOWE as well. They were the original sponsors of associated health plans on this side. They asked for a hearing. We held a hearing. After the hearing, people on my committee were saying, Golly, this is a problem for small business. What can we do to solve it?

It was also obvious from the discussion that there were some difficulties with the true AHP approach which we modified in the meantime. That is how we got to the position we are now in.

Mr. MCCONNELL. Mr. President, if the Senator will yield for one question, I have heard the Senator talk about the process by which he developed this legislation. Does he have any idea how many hours he spent consulting with the various entities across America that care about this and trying to move this legislation to this point?

Mr. ENZI. Mr. President, I don't have any idea. I spent a lot of hours and my staff people spent a lot more hours. Senator NELSON's staff and Senator BURNS' staff worked on this for so long that I actually thought maybe their staff people worked for me, too.

I was pleased spending days on end and sitting down, understanding all of the parts of this and getting it to work.

Another important part of this, Senator DURBIN asked me to talk to him about his plan. I made an appointment that same day and met with Senator DURBIN and Senator LINCOLN. We tried to work some of the principles which they had into this format. Eventually, we were kind of invited to leave by staff. We need to resolve more of that.

Mr. MCCONNELL. Mr. President, I say to the chairman that this has been a laborious and meticulous effort on his part. He has headed this up, and he has led us in an extraordinary way, and I, on behalf of all Members of the Senate, commend him for this accomplishment.

Mr. ENZI. I thank the Senator.

Mr. President, as an accountant I have to remind people that this bill is not a case of subtraction. This insurance plan is an addition. It will bring additional insurance to people. There are 27 million people out there who are uninsured. This will bring a number of them into the market. It will also allow people who are already insured to increase the amount of insurance which they have because they will be able to save some dollars. I am sure they will put that back into insurance and into more benefits for people. So it is an addition, not a subtraction, and it will bring in newly insured people.

One of the things I ask people is, when you go to the dry cleaners tonight to pick up your laundry, can you look that person in the eye and say, I don't think you deserve health insurance because you might not demand enough for yourself? So I am going to save you from yourself. Can you say to the mom and pop who are running the business down the street from your home, You don't deserve health insurance?

As you go home today, as you leave the Hill, think about the people around you, the regular people, the cab driver, the worker at the dry cleaner, the person at the neighborhood restaurant, all of those people who often you may not notice, the real people who make the world operate. Many of them do not have any insurance. Some may even own the little business around the corner and still are not able to have insurance. We always assume that if people own a business, they make a lot of money. There are times that the employees make a lot more than the owner of the business. They always have to pay themselves last.

As Senator BURNS said, when he was in business he provided health care to his employees, but he couldn't afford it for himself and his wife. But you do that to keep employees. I am not talking about deluxe insurance, I am talking about any insurance.

When people get the kinds of screenings that they would like to have, or even get the screenings they would like to have, and then find out there is a problem, if they don't have any insurance, they can't get anything done unless they pay for it.

We are not talking about the employees at the big chain hotels or the big chain restaurants. We are not even talking about the employees at Wal-Mart. We already said to them you can form whatever kind of benefit package you want. You do not have to answer to any State. You don't have to have review or oversight by the insurance commissioners.

Those are all things we provide for in our bill. You don't have to meet any State requirement. So instead of 35-percent administrative costs, you only pay 8-percent administrative costs. I am not talking about deluxe insurance, I am talking about any insurance.

Right now in several States, there is only deluxe insurance. Did you know that in some States there may be only one insurance provider because others have been driven out of the market?

I hope people will take a close look at this bill. I hope the other side will offer some amendments which are relevant to this bill and let us work through the bill. I hope, if the only way we can maintain germaneness is through cloture, that they will join in cloture because there are thousands of businesses out there that need insurance. They need hope. They want to ensure their employees. Think about that—27 million uninsured.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, while he is still on the floor, I say to my colleague from Wyoming, I think from all of us, I thank him for taking an earlier position on the health plan bill that passed the House. In my view, and I think in the view of lot of us, it was badly flawed. Thanks for the Senator's efforts over an extended period of time, along with our colleague, Senator NELSON of Nebraska, to take that product and make it better, and for your willingness to work I think in conjunction with Senator SNOWE to improve on it further, to be responsive to the concerns that a lot of us are raising, I wanted to go on the record.

As I said yesterday—and I will say it in front of my colleague—I find that he and Senator NELSON of Nebraska are two of the most thoughtful Members we have in the Senate. It is a pleasure working with you.

One of the disappointments that I find around here is sometimes even when we appear to agree on things, it is hard to get anything done. In this case, there appears to be pretty good agreement that if we could somehow find a way to harness market forces, we could bring down health care costs for small business and their employees and find a way to pool the purchasing power of those small businesses and our employees could maybe bring down health care costs and get a better selection of options from which to choose.

There has been a fair amount of discussion today and the days leading up to this debate over mandated coverage that certain States offer. I will give an example of one State in our experience with respect to mandates.

Before I came here, in my last job I was Governor of Delaware for 8 years. Roughly 10 or 12 years ago we learned, to our alarm and dismay, that Delaware had the highest rate of cancer mortality in the country. We also learned at the same time that while we had the highest rate of cancer mortality in the country, we did not have

the highest rate of cancer incidence. In fact, we were at number 20 or so.

We looked at those numbers and sort of scratched our head about them to figure out why we were No. 1 in cancer mortality—which is the last place you want to be—and number 20 or so with respect to the incidence of cancer.

We pulled in some people a lot smarter than me to look over those results and asked: What is going on here? Why the high cancer mortality number, particularly in light of the fact that cancer incidence is more like the middle of the pack?

After assessing the situation for a while, they said: We conclude—and we are fairly sure of this—the problem is, in your State, in Delaware, you do not do a very good job of early detection and treatment of cancer. If you want to bring down your cancer mortality number to be closer to your cancer incidence number, you have to do a better job of early detection and treatment.

We took that charge seriously. We went to work in three areas: The first of those, Delaware at the time, was one of the higher ranking States in terms of incidence of smoking, tobacco usage. We said one of the things we want to do is reduce the use of tobacco products. We decided to start with young people to reduce the likelihood young people will start smoking and continue to smoke. We made it more difficult for them to have access to tobacco products. We also reduced the opportunities for people to smoke indoors, an effort that continued under my successor.

The second thing we did was, with respect to expanding the opportunity for people to find a health care home by expanding opportunities for people to participate in Medicaid and the SCHIP Program for young children, partnership between the State of Delaware and the Federal Government as other States participated, too.

The third thing we decided to do was to say maybe we ought to have health insurance plans in our State offer as part of their package screening for certain kinds of cancer. For example, mammography screening for breast cancer, colorectal screening, cervical cancer screening, and a couple of others. We did all those things roughly 10 years or so ago. Every year we have had an opportunity to find out how we are doing with respect to cancer mortality and cancer incidence.

I have a chart. Delaware is small, so rather than use 1 year's numbers we look at 5 years. We have a 5-year rolling average. We went back to 1989 to 1993, when Delaware was No. 1 in cancer mortality. In the next 5-year period, 1990 to 1994, we were No. 1. In 1992 to 1996 we were No. 1, and so on. During the 1990s and into the decade we start out No. 1. We were the first State to ratify the constitution and our State slogan, which is ''We are the first State.'' We like to think it is good to be first. This is one thing we do not want to be first in.

The State that was No. 1 in cancer mortality for too many years started to drop by 1997 when we fell down to No. 2, and we continued to drop so that by the year 2000 we were down to No. 5.

I am happy to report standing before the Senate today that in the most recent numbers which I think run up through 2003, we dropped out of the top 5. We might still be in the top 10, but we know we are not in the top 5, and certainly not No. 1. We are heading in the right direction. I will not be happy until we are No. 50.

I would like my colleagues to consider that all of our States are different. Delaware is different. Wyoming is different from Oklahoma. We all have different priorities. We had a real problem in Delaware. We still have a significant concern with respect to cancer mortality. We developed a good game plan and we implemented that game plan. And lo and behold, it is working. It is actually working. We want to make sure it continues to work.

Reducing cancer mortality is like the Navy guys changing the course of an aircraft carrier, turning an aircraft carrier. The same is true as we try to reduce cancer mortality. It is a slow process. It is not an easy process. It takes time. If you stick with it, you can turn aircraft carriers. You also can bring down cancer mortality numbers.

How does this relate to the debate today? It relates because an earlier version of the association health plan legislation passed by the House any number of times does not let us do in Delaware what has proven to be successful in reducing cancer mortality. Even with the efforts of Senator ENZI and Senator NELSON, as this bill came to the floor, it did not let us continue in Delaware requiring the screenings for mammography, screenings in colorectal, prostate, and cervical cancer. It does not help us do those things.

With the amendment that may be offered or suggested by Senator SNOWE, we can do some of this stuff, not all of it but we can do some of it. Particularly the breast cancer screenings would be allowed to continue, maybe one of the others.

The reason I bring this up, I want to keep in mind that States are different. What we have focused on in Delaware is what works—what works to reduce unemployment, what works to improve student outcomes, what works to get people off of welfare roles, what works in a variety of things. This is a multipronged approach that worked in reducing cancer mortality.

Let me talk more about the Enzi-Nelson preliminarily with respect to the Lincoln-Durbin proposal. They actually share some things in common, as I said earlier. They both say: Health care costs are a major problem in this country. They are a problem for little businesses; they are a problem for big businesses.

As we watch my generation aging and look to the future, when the boomers are in full retirement—and I might add, the generation of the Presiding Officer is in full retirement—we will see Medicare, Medicaid, and Social Security which today account for roughly 8 percent of gross domestic production, by the time our generation is in full retirement, 25 or 30 years, I am told that Medicare, Medicaid, and Social Security may well consume something like 16 percent of gross domestic production. The amount of spending for those three programs alone is roughly equal to 16 percent of our gross domestic production as a country.

If you look back over the history of our country, in the last 50 years or so we spend as a percentage of gross domestic product something like 18 or 19 percent of gross domestic production to run the whole Government. If we are looking at 25 years or 30 years down the line where we are spending 16 percent of gross domestic production just to run three programs, with nothing for the environment, nothing for housing, nothing for defense, nothing for homeland security, nothing for education, that is a scary prospect.

So the concerns we have about finding a way to constrain the growth of health care costs are not just a concern of small or large business but a great concern for those in the public sector who worry about how to continue to fund and offer benefits through Medicare and Medicaid.

Senator ENZI took a few minutes to talk about the Durbin-Lincoln proposal. The proposals are similar in a couple of respects: One, they say rising health care costs are a major concern. They are a concern not just for government, for big business, but a concern to small businesses.

Wouldn't it be great if we could find a way to somehow combine the purchasing power of a lot of small employers across the country and their employees, much as we do for Federal employees? All Federal employees do not work for one employer. We work for hundreds of agencies. The Senate is an agency. The House is an agency. We have the courts around here that are separate courts and agencies.

Throughout the country we are, in a way, sort of like small businesses. We talk about being three branches of Government, but we actually are, in a sense, small employers. There are big employers among us, bigger agencies, such as Defense, but there are a lot of small agencies that are much like a small employer.

What we have done to be able to constrain the growth of health care costs for Federal employees is to find a way, working with the Office of Personnel Management, to pool our purchasing power, to get a whole lot of health insurance products available to be offered to us, to give us the opportunity to shop among them and figure out what works for each of us best, what we can afford, the kind of benefits we are looking for, and then we can pick

and choose. We end up with a great cross section of product to choose from. Given the kind of purchasing power we have, we are able to constrain the cost of coverage. We have to pay something, I think it is about 25 percent of the cost of our coverage. But it is, frankly, a lot lower premium than otherwise it would be if we did not have the purchasing power pool.

When you add active Federal employees and Federal retirees, you add in all the families, we are talking about a lot of people, maybe as many as 6, 7, 8 million people, and it gives us a chance to have a real impact on what is available in terms of coverage and how much that coverage is going to cost.

Senator ENZI raised a question about the cost of the Lincoln-Durbin plan. The Lincoln-Durbin plan is different from where it was initially introduced, as I understood it. There is a tax break in their plan from which the cost arises.

He mentioned the cost over 10 years as much as $50 or $60 billion. It is a tax cut for smaller businesses that offer coverage for their employees. The reason there is a cost associated with the Durbin-Lincoln plan is because of that tax cut. Ironically, some of my colleagues have suggested that is one of the few times they recall our Republican friends being opposed to a tax cut. I know there are tax cuts they are opposed to, but that is the reason there is this cost. It is considerable.

In the conversation we had earlier this afternoon, I was sharing with my friend, Senator ENZI, it involves Senator LINCOLN, myself, Senator SALAZAR of Colorado, and a number of folks from the business community who were gathered around just to have a good discussion about the problems we face in trying to look for some common ground.

I said to Senator ENZI when I came to the Senate a bit ago, we had a side bar conversation while another colleague was speaking. It is too bad that conversation we had with the business community in Senator LINCOLN's conference, too bad we did not have that 12 months ago or 12 weeks ago. He shared with me a conversation that occurred maybe 9 months or so ago that involved him and some of my colleagues on this subject.

Senator ENZI is good, as are Senators DURBIN and LINCOLN, in reaching out to the other side and trying to find common ground. We need to find common ground. I remain convinced I am one of the people who, like Senator ENZI, sees the glass half full even when it is almost dry. As to this issue today, I think the glass is at least half full.

I cannot help but think, given the good will on both sides, that if guys like me and gals like Senator LINCOLN and guys like Senators NELSON and ENZI and DURBIN put it in their minds, we could find a way to further reduce the differences between our respective proposals.

I do not know what is going to happen when we vote. I guess we are going to vote on cloture tomorrow, I am told. I am not sure what is going to happen. I don't know if the debate will basically continue or, because of that, sort of end for now. If it does, I hope the discussion actually will begin in earnest, and discussion, certainly, with the principals on both sides who have interests in this issue, and that out of that discussion we come to a more satisfactory resolution.

One of the problems we have on our side—and I think Senator ENZI has heard this before—is sometimes, even when we pass what we think is a pretty good bill in the Senate, and we go to conference with a much different bill from our friends in the House, when the conference is created between the House and the Senate, we, as Democrats, are not always full participants in those conferences, and what comes out at the end of the day does not look a whole lot like what we passed in the Senate, or at least not enough. That is going to be a concern. And I just need to say that.

But having said that, we will cast our votes tomorrow and see what happens with respect to them. But I would say to my friend Senator ENZI, my hope is that if we do not come to resolution and this is an issue that continues to be outstanding. It is too important just to let it die. I hope we will have an opportunity—whether it is tomorrow or next week or the weeks after that—to find a common ground and get something done.

Mr. President, I brought these charts. We might as well use them. Actually, I think for a guy from Delaware they are actually pretty interesting. I do not know what these numbers look like in Wyoming. But when you look at the leading causes of death in my State—this chart goes back to about, oh, Lord, a dozen years or so. In the early part of the 1990s, about 32 percent of the folks who died in our State died from heart disease, about 26 percent died from cancer, 6 percent died from strokes, 4 percent died from chronic lower respiratory disease, 4 percent died from accidents, and 3 percent died from diabetes, and 25 percent died from ''all others.''

Keep in mind, in the early 1990s, cancer was right around 26 percent, heart disease was 32 percent.

Let's see what it looked like a decade later. Heart disease was at 32 percent, now it is down to 29 percent; and cancer, which was at 26 percent, is now down to 24 percent. The rest are pretty much the same, although ''all other'' is gaining. In fact, ''all other'' is in first place now, whatever ''all other'' is.

We are real pleased to see the drop in the number of cancer deaths. Does that sound like a lot over a 10-year period of time, to drop from 26 percent down to 24 percent? It is not. But as I said earlier, it is a little bit like changing that aircraft carrier. The numbers have dropped. We are convinced we are doing something right, and we want to continue what seems to be working.

I have a couple of other charts, and then I will close. This is a chart that goes back to the beginning of the 1980s—1980 to 1984—and up to 2002. The red numbers are the cancer mortality rates for the country, and the numbers above are cancer mortality rates for Delaware, starting in the early 1980s and going to the early part of this decade.

As you can see, the gap by around 1990—the early 1990s—the gap right here, was pretty large, back here, but it is even larger here. That is when we started doing something different, changing up our game plan in Delaware. And we are still above the national average here, but it is about half of what it was a decade or so ago. So we are convinced we are on the right path.

One more chart. My staff thinks this is not a very good chart, and maybe it is not. I kind of like it. Let's see if I can get it straight. We look here at the percentage of the reduction in cancers. It dropped between the early 1990s and the early part of this decade. The mortality rate of all cancers in Delaware went down by about 13 percent—a drop in all cancers.

The cancer mortality rate in the United States during the same period went down about 7 or 8 percent. The drop in the lung cancer mortality rate in Delaware, over the last decade, was, again, by about 13 percent. In the country, it went down by about 5 percent, in this same period of time. Colorectal deaths went down in our State by over 15 percent over that 10-year period of time, and down about 12 percent in the country. Breast cancer deaths in Delaware went down, in the last decade or so, by about almost 20 percent. In the country, it went down by about 12 or 13 percent.

And for guys like us—Senator ENZI and my colleague, the Presiding Officer—this is a real attention getter. For prostate cancer, the mortality rate in our State, in the last decade, went down by almost 50 percent, in Delaware, as compared to the rest of the country, which was about half that, roughly 25 percent.

I think that is a pretty good chart, and I am glad it was made up for us to look at.

The point I want to make is, actually sometimes we have these mandates, along with other things I mentioned earlier, and some positive things do happen in our respective States.

We are pleased with the progress we have made, and we have a long way to go in Delaware. We want to make sure we have the tools to be able to continue in that vein.

I have said my piece. I look forward to seeing how the smoke clears and what things will look like after tomorrow. We will just take it from there.

I yield back my time. Thank you, Mr. President.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Nevada.

Mr. ENSIGN. Mr. President, I will not be very long. I will be very brief. I

want to speak about the bill that the Presiding Officer, the Senator from Wyoming, has brought forth from the HELP Committee.

I have the honor of serving with the chairman on the HELP Committee. I think he has done a great job crafting this bill, which will offer more people the ability to afford health insurance in America.

We have heard reports about how many uninsured Americans are in our country today. The fundamental point is that a lot of Americans simply cannot afford to buy health insurance. And, many uninsured Americans are employed by small businesses. I have built, owned, and operated two animal hospitals, veterinary hospitals. As a small business owner, it is very difficult to afford to buy health insurance, not only for yourself, but, obviously, for your employees. One of the reasons it is difficult to buy health insurance relates to purchasing power. When you have a small number of people, it is difficult to go to insurance companies and negotiate effectively for good prices. If you have 20 employees versus a company that has 20,000 employees, the company with 20,000 employees has a lot more buying power and, therefore, can negotiate prices down more effectively than the smaller company.

The bill before us today establishes small business health plans, which will allow small businesses, such as the veterinarians, the restaurant owners, and the physical therapists to band together through their associations, and negotiate for health care coverage at prices they can afford. What this means is that a lot of people who are currently uninsured can become part of the insurance market. There is also a side benefit for the people who already have health insurance. A lot of people who are currently uninsured are young, healthy people who happen to want some type of health insurance coverage. If we bring these individuals into the health insurance market, they will help spread out the risk, which lowers costs for everyone else.

Now, we have heard criticism from the other side of the aisle saying that we are not maintaining the mandates that a lot of States have put forward. Opponents say that some people are going to be without coverage for mammograms, cancer treatments, and other services.

These same people today have no health insurance coverage whatsoever—isn't basic coverage better than no coverage at all? We would love to offer and be able to afford to offer everyone every type of service possible. But the reality is that a lot of people cannot afford health insurance plans today because insurance coverage has become too expensive. One of the reasons for this is that small businesses cannot pool together across state lines. Another reason has to do with mandates.

We talk about a lot of different proposals that can lower the cost of health care for hard-working Americans. Everybody campaigns and tells their constituents: We have to do something about the high cost of health care. We must do something. Let's act.

We have an opportunity to act now in the Senate. There is a good bill before us. We need to act on this bill so that uninsured Americans can come into the insurance market.

This bill is estimated, by an actuarial firm, to lower the cost of health insurance for small employers by as much as 12 percent. This is a significant number. Every dollar you lower the cost of health insurance makes more and more people able to afford it.

It is time for us to enact legislation that is actually going to be good for the American people, a proposal that will allow more people to be able to afford health care coverage.

Mr. President, the bill before us today goes a long way toward making health insurance more affordable for small business owners and employees. I encourage this Senate to get behind this legislation. Let's move it forward, work out the legislative differences with the House, and send a bill to the President that will help Americans afford health care insurance today.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, first of all, thank you for taking my stead in the Chair this evening so I could participate in this debate. I have been in the Chair 2 hours and 30 minutes and have heard quite a range of things.

Health care is a problem that affects the whole country today. We are going to spend in our Nation $2.3 trillion this year. The largest amount of money we are going to spend on anything in our country, we are going to spend on health care, and one out of every three dollars we spend does not help anybody get well.

We ought to ask ourselves—with 45 million people truly not covered in an insurance product, with the cost of health care rising double digits every year, with the cost of drugs skyrocketing, with the cost of hospitalization, emergency care skyrocketing—how is it we are spending all this money, with $1 out of every $3 not helping somebody get well, and costs are going through the roof?

It is because we have some real structural problems. This bill is meant to address a small portion of that. It is not the end-all, answer-all to our problems in health care. We all realize that. But this is something we can do in the short term that will make available an opportunity for costs to be controlled in a small area of our economy that will have impact and will create accessibility.

I would say we all in this body want everybody to have access to health care. The question is, Who pays for it? Right now, in terms of Medicare, our grandchildren are paying for it because it ran a $120 billion deficit last year. In other words, we borrowed $120 billion to run Medicare last year because that is the amount of money we did not have coming in from Medicare premiums.

The whole question on how we address health care is going to be: How do we get a better system that will give more people access, that does not waste that $1 out of $3? That is what we have to be concerned with. We have the brains, we have the science, we have the facilities, but something is wrong. What is wrong is there is not a competitive system out there where we allocate scarce resources based on quality and value and price.

This bill will move a little bit in that direction. There are going to be a lot of areas where we move. The one thing I have heard from the other side that I agree with today is, we ought to be emphasizing prevention. I agree with that 100 percent.

We have 19 different agencies in the Federal Government that have something to do with prevention. We are going to be introducing a bill that pulls all those together into one and has a leader who is emphasizing prevention and what we can teach the American people about saving money, preventive health care. As grandma used to say: An ounce of prevention is worth a pound of cure. And it works every time.

We know we can prevent diabetes. We can stop 50 percent of diabetes just with education, but we don't have it. We are wasting resources and duplicating resources. We have opportunity costs from programs that are designed to do it and don't do it well. Others do it much better, but we are still funding the ones that don't do it well. There are lots of problems we have.

I want the American people to understand that the choice that has been outlined by those who oppose this bill today isn't a choice of whether we have to have mandates. It is a choice of somebody who has no care now, no mandate, versus getting some care. If we do our job on prevention, then we will be educating the American people. But the ultimate health care responsibility in this country isn't the Congress. It isn't the States. It is the individuals who make choices about what is going to impact their lives and what value they want on their health care. That is why HSAs, although they have been blocked, need to be expanded vastly. They need to be funded better. They need to have an application for chronic care, and they need to have a tax deductibility to bring you up to the level of that so that we put everybody's skin in the game, so you know you are going to make a choice based on what is valuable to you.

Everywhere else in this country, we have trusted markets to allocate scarce resources. We are a little timid about how they are doing it in oil, but the fact is, the market is scarce, and the price is up. As soon as either demand decreases or supply increases,

the price will come back down, or some other form of energy is going to be there to supply it, such as agrifuels.

We have to trust the market to help us because we can't afford what we have promised. We can't afford what we promised in Medicaid, in Medicare. The money is not going to be there in 10 years. It is going to start winnowing away. So what are we to do? Continue to create a charade for the American people that says yes, we can, or start with one small step with this bill which offers availability through group purchasing, expanded purchasing power, lowering the overall risk to a million people? Why would we not want to do that?

Is it perfect? No. There isn't a bill we pass that is perfect. But this is a step in the right direction, although it does walk over some State mandates, I agree. But the problem is, Medicaid walks over State mandates every day. Medicare walks over State mandates every day. They set a mandate.

We have two choices in health care: the Government is going to run it all, or we go to the private sector where we really trust the market to allocate and protect those who need the help, those who can't help themselves. Those are the only two choices we have on health care. If you think we have problems now, wait until the Government runs it all.

I am a physician. I have practiced since 1983. That is 23 years. I have delivered 4,000 babies. I have done every kind of operation you can think of. I have seen a system decline based on how insurance has been applied to it and copying the mandates of the Federal Government. So we are in a mess on health care. Let's get out of the mess. Let's start with this, but let's don't stop there. Let's start with prevention. Let's make sure there is competition in the pharmaceutical industry. We don't have it.

As a practicing physician, there is no competition in the pharmaceutical industry. Drugs that do exactly the same thing and are priced the same way, nobody wants an increased market share. The Federal Trade Commission ought to be asking why. Why don't they want increased market share? I believe there is collusion on sharing of markets in the pharmaceutical industry so that they can keep the prices high. We need worldwide competition on pharmaceuticals. If we will do that, we will get a lot of bang for our buck.

There is even collusion when it comes to the generics. The FDA has created this wonderful system which enhances no competition for 6 months to 18 months for the first person who comes out with a generic. What is that all about? That is taking away from the market.

There are lots of problems, but this is a good start. It is not perfect. Is it as good as we can get? It probably is right now. But it starts us down the path on what we need to do to fix health care in this country. That is competition.

We need transparency. We have seen recently hospitals not wanting to give their rates, doctors not wanting to give rates, Medicare not wanting to publish rates. Why not? Let people know what they are supposed to be getting charged. Let's have a little open sunshine on the health care industry.

Let's talk about the 19 percent of every dollar that goes into the health insurance industry that never goes to help anybody get well. Let's talk about that. Let's create real competition in the health insurance industry. The more people get into it, the more competition we will have.

I thank the Senator for filling in for me so I could take the time to address the Senate. Our goal is making sure everybody has access to care and doing it in a way that our children can afford to pay for it because we are not paying for it today. We need to be mindful of that as we make those decisions. This bill starts with that.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BURR. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. COBURN). Without objection, it is so ordered.

Mr. BURR. Mr. President, as you spoke on this bill, you inspired me to come back over for another opportunity to talk. To put in context why we are here, you have to talk about where we have been this week. We started this week focused on exactly what you raised, and that was the inflation factors that go into health care.

On Monday, we were slated to consider two different proposals. One was a proposal that limited the liability that all medical professionals have, and we have seen liability premiums rise at a rate that is unsustainable for doctors across the country. That bill was quickly questioned as to whether we would bring it to the floor. Some argued that there was no need to; it is not a problem. We were forced to have a vote on whether we could proceed to consider the bill. We didn't vote on the bill. We didn't offer amendments on the bill. We had a vote on whether we could proceed, which requires 60 Members of the Senate to support. We didn't get 60 votes. The American people didn't get cost reductions because some in this body chose not to extend the privilege of debate and the voice of the American people in the amendment process into that bill.

We turned around and we introduced another bill. The bill's coverage applied to those specialists who are OB/GYNs; in other words, individuals who deliver babies, something that is vital in this country.

I know the Presiding Officer is, in fact, an OB/GYN. He delivers babies. He delivered babies throughout his career in the House of Representatives. He would leave the House, he would go home and deliver babies on the weekends so that he could keep his practice alive. He doesn't have the luxury now in the Senate. That is a shame because he was good.

There are communities all across this country that have lost their OB/GYNs, not because they became U.S. Senators but because they can't afford liability insurance anymore. They have been forced to leave rural America and go to urban America where they are under the umbrella of coverage of a large medical institution, in all likelihood affiliated with an academic institution.

What happened on Monday night when we took up liability limitations for those across this country who deliver babies? We didn't get the opportunity to debate it. We didn't get the opportunity to amend it. We had a motion we had to vote on to proceed. Because 60 Senators didn't agree to move forward, that died a quick death. Two bills that addressed substantive ways to cut the cost of health care died in a matter of 1 hour on the Senate floor because people didn't think it was important enough to address things that are inflationary to the cost of health care.

I said shortly after that I was going to come back to the floor because I thought it was important for my colleagues on the Senate floor and people in the gallery and across the country to hear real stories from real Americans.

In North Carolina, we have a lot of people who are suffering today because they lack insurance. So the third part of Health Care Week is to take up a bill that allows small businesses—really the heart and soul of America—to purchase as associations, as groups, to negotiate en masse because they don't get the luxury of the benefits of large corporations to leverage the cost of health insurance. For that reason, many small businesses today can't afford to provide health care and to keep the doors open of their businesses. So they choose to hire folks and to employ them and to pay them but not to extend health care benefits. Those are numbers that are counted in the national uninsured population.

In North Carolina, we have 671,000 small businesses. Small businesses make up 98 percent of the firms in North Carolina. Women-owned small businesses have increased 24 percent since 1997. Hispanic-owned small businesses have increased 24 percent since 1997; Black-owned small businesses, 31 percent; Asian small businesses, 74 percent. Are they any better off because of the categories they are in to provide health insurance for their employees? No, because they are caught in the same problem. They don't employ enough people to negotiate like the larger corporations.

In North Carolina, there are 1.3 million uninsured individuals, and 900,000

of those uninsured individuals are in families or on their own with one full-time worker. One full-time worker is in that house either with a family or is the individual in the house. The opportunity with this one bill is that we will have 900,000 people who potentially have the opportunity for the first time to be covered by health insurance.

Many run to this floor, and they talk about what we need to do as a Congress. They don't really mean we need to pass legislation that creates an affordable health care bill. What they mean is they would like for the Federal Government, through taxpayer funding, to produce a benefit we pay for for anybody who is without health care.

I think we have the right approach. The right approach is to make sure that small businesses can band together, that they can negotiate with the private insurance market, that they can offer a benefit, for the first time for many of them, to their employees, and the retention of their employees is better because that benefit is now extended.

Do you realize that the most expensive benefit that is offered by a business today is health care? It is not retirement, not any of the things that historically we have looked at. The health care benefit is the single most important thing.

I heard the Presiding Officer talk about the future and the fact that our children are the ones paying for Medicare today.

That is, in fact, right. Three things control our competitiveness in the world, and they are health care, energy, and labor. But I guarantee you, when we bring up energy, we are going to be blocked from proceeding because we will try to bring down gas prices and try to come up with things that bring stability in energy. Some would rather see nothing happen on the Senate floor.

I have an individual who is in the appraisal business in North Carolina who wrote to me and said that small businesses need help with insurance. That is in big letters. He says he is now paying $986 per month for his wife and himself. This is for only 60 percent coverage and a $2,500 deductible. He says he knows people with group insurance paying $600 for 80 percent coverage and a $250 deductible, and many of those have dental insurance as well. He said his policy provides none. ''Please help me out.''

This came from a store owner, and it says that as a small business owner, it is important to enable some economy of scale in allowing franchises to obtain more affordable health insurance.

The economies of scale is exactly what we are on the Senate floor to debate. I might add at this time that this debate really didn't start until several hours ago because on the third bill—this bill—we had to vote on a motion to proceed, which we won this time, and we had to delay some 30 hours before we could engage in the amendment process and general debate.

This comes from an individual from Hickory, NC. She said that as a parent and an employer, she knows the importance of having affordable insurance and the financial devastation that occurs when you have no coverage. Unfortunately, there has to be a tradeoff. She says she has only one of two options to keep her doors open: either her employees have no insurance or they receive a livable wage. When there are no viable alternatives for employers to purchase reasonably priced insurance, the losers are her employees.

What are we here debating? We are debating a change from today's policy. What is the choice employees of small business have today? It is a choice between nothing and nothing. That is unacceptable. That is why the chairman, Chairman ENZI, has worked so hard to carefully craft a bill that doesn't bypass those who are charged today with regulating insurance, every State insurance commissioner. But it incorporates them fully and allows products that can be created that, for once, are affordable. Sure, they don't have all the bells and whistles. They don't cover the full scope of coverage that every insurance product has today. But when your options are nothing and nothing, isn't it reasonable to believe that we can have a debate about creating something and nothing? Isn't that, in fact, why we are here?

In South Carolina, there is a textile company, a small business owner in Greenville who says that providing health insurance is becoming an unbearable hardship for small businesses such as hers. She is a widow, self-employed, and her health insurance is an expense she can hardly afford. Like many of her employees, she has a $5,000 deductible, and her monthly premium constantly increases 35 to 40 percent every 6 months. Most would say that is impossible, but I have her name and her address, I have the city in which she lives, and I have her company name. She wrote to me.

It is individuals who are turning to the U.S. Senate now. The House passed it. They are saying: Please produce something for us.

Here is one from Alabama. It is not all North Carolina. This is an owner of a nursing services company who said that the cost to cover one employee is $225 a month, and it is $617 for full family coverage, which is up 6 percent over last year. She recently lost a long-term employee to a larger company because that company could afford to pay 100 percent of the employee's health care costs. She thinks it is simply unfair that we don't do anything.

Janice is from Kentucky. She is the owner of an elevator company. She was hit with an astonishing 60-percent increase in health care premiums in 2002. There are a lot of similarities in the last letter. Some might have thought that is impossible. It is not.

Here is another one. Some of this increase in cost was passed down to employees because her company simply could not absorb all of the costs. If this trend continues, which she fully expects, they will have to drop the coverage she has provided for employees for years.

The writing is on the wall. We need to do something to relieve the pressure for small business in America or the uninsured rolls will increase. The rolls will not decrease because these small business owners cannot afford to continue to supply health care as a benefit.

Here is one from Mississippi. As a new small business owner in Mississippi, he finds it harder every day to make sense of why he pays three times as much for family health insurance as he paid when he worked in the same industry for a large company. He says there needs to be a way for his company to offer his employees similar high-value health insurance that he was offered when working with the big guys at a reasonable rate. Small businesses are at an immediate disadvantage simply because they are small, he said.

I talked earlier today about my election to the House of Representatives, when the Presiding Officer and I came in. I came from what I considered to be a small business, but it was over 50 people. We had adequate health care. I paid 25 percent, and the company paid 75 percent. I got to Washington as a Member of Congress. I found that my choices for health care increased in number, but I thought it was probably most prudent to choose, in fact, the same plan I had in the private sector, the same company, the same plan. I paid the same 25 percent, the Government paid the same 75 percent. What was the one difference? The one difference, now that I was part of 2 million people who worked for the Federal Government, was that my premium went up $50.

You see, there are some that will argue that the only way to solve the health care crisis in America is to have the Government take it over. If you want to solve small businesses' problems, let the Government negotiate a health care plan for them. Well, my experience with the Government negotiating health care is that it costs me more money. I would be willing to bet that most will find that to be the case. Incredibly, nobody is calling my office saying: I wish you guys would negotiate for me, or I wish the Government would take this over. Don't provide me choices, just give me one. I don't want to choose.

This is from Larry in Mississippi, who owns a small company. He has little buying power and few affordable options for health care. It is similar to what has happened in so many States, where one insurer controls more than 75 percent of the small-group market. This lack of competition resulted in an 80-percent increase in the last 2 years for his John Deere dealership.

I will tell you what, if there is anybody I would work hard for to find him

a deal on health insurance, it is a John Deere dealership. He increased the deductible from $250 to $2,500. He says that if he doesn't receive relief soon, he will be forced to drop all insurance coverage or lose his business. So he has an option: He can close the door, and everybody who works for him would be out of business.

You see, we are here because today the choice that small businesses and their employees have is a choice between nothing and nothing. All we are here to do is to suggest that we engage in this bill and that we have an up-or-down vote about something. Nobody will see this as a silver bullet that solves the health care crisis, as the Presiding Officer said earlier. That will take a much more in-depth engagement, a much more difficult debate on the Senate floor. We really will bring in the experts as we try to provide the changes that are needed so our children have the same benefits we have. But it doesn't make me too optimistic if we cannot solve this simple thing that so many small businesses are experiencing today.

Here is one from Virginia, not too far from us. The owner of a small industrial service firm is facing a crisis trying to provide health insurance for employees. His small business, with 20 employees, has struggled for the past 10 years to provide a health benefit plan. He has been able to continue to provide this insurance only by reducing coverage, raising individual office fees, and asking his employees to pay a higher share of the monthly premium. Underwriting penalties for small groups and rising medical costs and increasing mandates from government are collectively squeezing his small business to the point where meaningful health coverage will simply not be affordable.

I thought our job was to try to bring more people under the umbrella of coverage. I thought that was the objective, to try to create new products, create more affordable products, make sure that health care is not just more affordable but more accessible.

Here we are on the Senate floor with one of the most carefully crafted bills I have ever seen—a bill that a group of actuaries from a well-respected firm found would reduce health insurance costs for small business by 12 percent in today's dollars. That is $1,000 per employee. Is somebody in this institution telling me that small business employees across the country don't want to save $1,000 or that they don't want to have the opportunity to have less of their out-of-pocket money go to health care coverage or that we should ignore a well-respected actuary?

By the way, the actuary also found that S. 1955 would reduce the number of workers who are uninsured by about 8 percent, or 1 million people. This would automatically bring a million people under the umbrella of coverage. That hits home to me because I have 1.3 million uninsured in North Carolina. I have 1.3 million uninsured individuals, and 17 percent of North Carolina's population is uninsured today; 16 percent are uninsured nationally in this country.

Do you realize that only 205,000 of those 1.3 million uninsured are part-time workers? There is this belief that that number includes all part-time workers. If we could just make sure Wal-Mart supplied health insurance, this would all be over. No. The majority of mine—1.1 million—in all likelihood work for small businesses. They are uninsured. And 900,000 of them certainly are in a family where they could have a chance at health care coverage if, in fact, we pass this bill.

The Congressional Budget Office has also looked at the bill, and they found similar numbers of newly uninsured Americans. If S. 1955 were signed into law, CBO estimates that nearly 750,000 more people would have private health insurance than under current law. I guess that is the key. I guess some don't want there to be private health insurance. When we leave the marketplace alone, when we set it up so it is fair, it is amazing what competition does.

As a gentleman from Mississippi said, when one company controls 75 percent, where is my negotiation point? We are talking about letting national associations band together. We are talking about potentially shopping for national coverage, with national firms, but letting the State insurance commissioner regulate the product. I am not sure there is a downside to that, unless the downside is that we have now brought more individuals under the umbrella of coverage and this issue begins to diminish from a standpoint of the politics that comes along with health care.

Mr. President, I am going to end for the evening. I will not end for the debate, though. I still continue to get letters into my office that are real stories about real people. I think many times real people are forgotten on the floor. We get so wrapped up in the debate of issues that we forget that everything we do here affects somebody in this country or in the world.

Each time we stop long enough—maybe this weekend; I am not sure we will finish this bill this week; I hope we do—we figure out who these uninsured are. Maybe everybody will take an opportunity to go to a small business if they haven't visited one in their State, and they can ask those small business owners: What is the health care market like for your employees? I have a feeling what they are going to hear is what I have shared with you from real businesses, real owners about real people who can't afford what is available to them today.

There are in North Carolina 671,000 small businesses that desperately want a choice of something. Today all they have is nothing versus nothing. Their employees have nothing or nothing. Not a very good choice.

I am glad we are on this bill. I am glad the 30 hours is over. I commend Chairman ENZI for legislation that is incredibly well crafted. It is focused exactly where it needs to be, and that is to make sure plans are not cherry-picking, to make sure that regardless of the money that is available, there is a health care option so an employer and their employees can decide whether it is, in fact, affordable.

At the end of the day, it is my hope that Members of this very historic institution will remember the folks back home who sent them here, that they will remember the next generation we are obligated to represent, that we have an obligation today to make sure individuals who want to be covered have an affordable option to be covered, to make sure we fix some of the problems so the next generation, our kids, don't fight the same challenges we fight today.

I am convinced this debate will continue, and at the end of the day, I am convinced the American people will win regardless of what the intent is of some in this institution.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. DEMINT.) The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, something is wrong when 45 million Americans, 8 out of 10 of them in working families, cannot afford access to quality health insurance. This past weekend I met a woman in Des Moines who has been without health insurance for herself and her daughter since her husband died several years ago. She works hard as an administrative assistant in a small law office. She lives, like many Iowans, from paycheck to paycheck. She cannot afford private health insurance and she makes too much money to qualify for the State's Children's Health Insurance Program or Medicaid. This has consequences. She has not had any screenings or preventive care in years. Her daughter does not go to the doctor regularly, despite the fact that their family has a long history of diabetes and cancer. She knows she is at risk but cannot do anything about it. What happens to her if she gets sick?

Many people believe the United States has the best health care system in the world—the best treatments, the best medical technology, the best pharmaceuticals. But this is a cruel joke to the uninsured, including more than 8 million children, because they are forced to make do with substandard care or none at all. The result is a paradox. The United States has a world-class health care system, but we fall behind most industrialized countries when our general health outcomes are

measured. In 2000, the World Health Organization ranked our health care system 37th in outcomes that our health system provides. Just this week, CNN reported a new study which found that the U.S. ranked next to last in infant mortality among industrialized countries.

Bear in mind again that health insurance is not just about seeing a doctor when you are sick; it is about prevention as well. If you have insurance, you are more likely to have a relationship with a doctor or health care specialist who knows you and your health history. You are more likely to have access to preventive care so that chronic disease can be prevented in the first place. Without health care coverage, minor illnesses turn into major ones and small incidents turn into chronic conditions. Once this happens, it becomes almost impossible to afford quality health insurance without restrictions on benefits.

That is why this debate is so important. This week we are considering a major overhaul of the insurance system in an effort to help provide health care coverage to small business owners and their employees. I applaud the goal, but this particular legislation before us now is sorely lacking and will not provide access to quality health care at affordable prices.

I oppose the bill before us for the following reasons:

First, the bill eliminates consumer protections found in current State regulations, including in Iowa. In Iowa, under the bill, 840,000 consumers would lose coverage for diabetes testing supplies and education, emergency services, mammography screenings, State mental health parity, and well child care. They would also lose guaranteed access to dentists, nurses, nurse practitioners, and other providers. Iowa does not have a laundry list of coverage services. Iowa State regulations guarantee quality insurance. But S. 1955 would do away with the compromises that were worked out at the State level to guarantee quality.

Secondly, the supporters of this bill argue that the bill would lower insurance premiums for small businesses. What they don't tell you is that it comes at a cost. Many people, especially those who are older and sicker, would see their insurance premiums increase under the legislation, even with the changes found in the managers' amendment. CBO found that insurers will charge significantly higher premiums to those who are sicker, older, and otherwise less favorable to insurance companies. They will do this in order to reduce health insurance premiums for small firms with workers who have relatively low expected costs for health care. Imagine the shock of business owners all across America, including many I have met with recently in Iowa, when they are billed for the first insurance premiums under the new bill.

So keep in mind, of course, you can always get cheaper insurance, but what does it cover, at what cost, and what are the premiums going to be for the person who is covered?

Third, and importantly, this bill would undermine State efforts to guarantee coverage for preventive services. As I have often said many times, we don't have a health care system in America, we have a sick care system. If you are sick, you get care. But we spend precious little money and we have very few incentives for keeping people out of the hospital, keeping them out of the doctors' offices, and keeping them healthy in the first place. This bill would make it worse. In short order, insurers would offer stripped-down policies that do not cover preventive services. The result would be the elimination, as I said, of cancer screenings, well child care, mental health services, access to certain physicians or nurses or other providers such as chiropractors, for example, who might give you good care and keep you from getting a chronic condition, something that might cause you to have an operation in the first place. So importantly, this would mean elimination of benefits for everyone, not just small business.

Americans should have access to quality, affordable health care coverage. Coverage that is stripped down is not sufficient, and we shouldn't settle for it. People's lives, their livelihoods, their ability to contribute to society will all be undermined if they are not healthy.

I met with small business leaders in Iowa. Of course they want relief from high insurance premiums or from not even being able to get policies at all for their workers. We all do. Small business is the backbone of my State. And they need—they need—to have some kind of insurance coverage for their workers. With regard to this bill, what I have said to them is, don't think it is this bill or nothing. I also ask them: Are you willing to lose access to quality health insurance? Just check with the American Cancer Society. We have cancer societies in our small towns and communities all over America. People who run small businesses contribute heavily to our local cancer societies. But here is what the American Cancer Society said:

> In one stroke, this bill would erase all that state legislatures have done to prevent and more effectively treat cancer by ensuring access to life-saving screenings for breast, colon, and prostate cancer, cancer specialists coverage for evidence based off label drug use, clinical trials, and proven smoking cessation services.

That is from the American Cancer Society about this bill.

I ask all my friends; I ask anyone who has had a history of cancer in their families: Would you want insurance that doesn't cover screenings for breast cancer or colon cancer or prostate cancer?

How about the American Diabetes Association. We know that diabetes is hitting people younger and younger all the time. We have to do something to prevent diabetes. But here is what the American Diabetes Association said about this bill:

> We must ask ourselves how people with diabetes will be able to pay for a disease that costs an average of $13,243 per person to manage. Unfortunately, it will be our emergency rooms and Medicaid system that are forced to pay.

I ask my friends who are diabetic or who have family members with diabetes: Would you want insurance that doesn't cover diabetes-related services?

Those are just two examples, but there are many others. So, again, it is not this bill or nothing. There is a better option out there that will guarantee coverage for these services and at the same time provide small business access to quality insurance.

One realistic solution that I support would be to give small businesses the option of joining a program modeled after the Federal Employees Health Benefits Program. That is the program that covers us here and we love it, believe me. All Senators, all Congressmen, Supreme Court Justices, all our Post Office people—anybody who has anything to do with the Federal Government belongs to the Federal Employees Health Benefit Program. It is great coverage. Why shouldn't small businesses have access to the same kind of program we have?

That is why I have joined with Senators DURBIN and LINCOLN to introduce S. 2510, the Small Business Health Benefits Plan. Here is why this bill is superior to the bill we have before us:

First, it would create a larger purchasing pool, a nationwide pool, rather than the fragmented pools that will be created under S. 1955. A national pool would reduce insurance rates for everyone.

A few years ago, before I came to this place, I sold insurance. There is a principle in insurance that we all know: The more people in the pool, the cheaper it is for everybody. It is one of the fundamental principles of insurance. The more people in the pool, cheaper it is for everyone. So you want a big pool when you are dealing with health care.

S. 1955, the bill before us, sets up thousands and thousands of small pools. But the Federal Employees Health Benefit Plan is one big pool. So if you have that national pool, insurers will be able to offer a range of plans such as we have now. Every year we have open season and I can choose from—I don't know, I didn't count last time—maybe about 18 different plans. But the Office of Personnel Management would negotiate the rates and benefits offered under the plans.

Should they do that? OPM has been negotiating with private plans for decades. They have consistently negotiated better rates for Federal employees than have been achieved in the non-Federal market.

All the Senators here, all those who love the free market system—you will hear speech after speech praising the

free market system, but everyone here belongs to the Federal Employees Health Benefit Plan, and OPM is the one that manages the rates and negotiates the rates in these plans. As I said, they are better than anything that has ever been achieved in the non-Federal market.

Second, our bill offers a tax credit to small employers that would help offset the cost of premiums for employees if they make $25,000 a year or less. S. 1955 doesn't do this. There are no tax breaks for small businesses in S. 1955. There are more than 26 million Americans making $25,000 or less working in small businesses. Of those, 12 million, or 40 percent, are totally uninsured. That is what we want to get at.

I will be glad to go to any small business with those who are advocating S. 1955. We will take S. 2510 and we will take S. 1955, we will lay it out there and let the small business owner decide which one they would want to have. I would love to see that happen. I tell you I know what would happen: They would pick S. 2510, the one I am talking about, the one that would give them a tax break for covering and would provide quality insurance.

Third, our bill does not preempt State consumer protection laws. S. 1955, the bill before us, would do away with the guarantees I discussed, the guarantees of preventive services such as breast cancer screening, mammography, cancer, prostate screening, things such as that. By contrast, our bill would keep State insurance laws where they are. The insurance would cover mammograms, cervical cancer screening, diabetes testing supplies, immunizations, and on and on.

If you are a small businessperson and you happen to be watching this session and you are listening to my remarks, you are probably saying: Senator HARKIN, that all sounds good. Why don't you get S. 2510, the bill you are talking about, up for a vote?

Welcome to the unreal world of the Senate, when we are not allowed to do things such as that. We have S. 1955. The majority leader has, if you will pardon the expression, filled the tree. That is sort of gobbledygook around this place which means they have blocked us from offering any amendments, and then we are supposed to vote on cloture on the bill, which means debate comes to an end on the bill and you can't file anything that is not germane.

Tomorrow night we are going to be asked to vote for cloture on it? I am not going to vote for cloture on that. If you want to have an open Health Week here and you want to bring out S. 1955, leave it wide open so we can offer S. 2510 and we can have a debate on it and have up-or-down votes. I am all for that. I think the small business community in America ought to know that we are not being allowed to bring up our bill for amendment and discussion. I think our bill would pass. I think the small business community would support it.

But as I have understood, being out in Iowa last weekend and as I talked with small business owners, they have sort of been led to believe it is S. 1955 or nothing. And of course they will take S. 1955. If I thought that was all there was, I would probably take it, too. But that is not the option before us. We have better options than S. 1955. We have the option of S. 2510, the bill I spoke about, introduced by Senator DURBIN and Senator LINCOLN.

Again, it is unfortunate—not for us. It is not unfortunate for us. We have great health care coverage. We have great health care coverage. It is not unfortunate for us but unfortunate for the small business owners and the 25 million Americans who work for small businesses—12 million who do not have any insurance at all. This is what is unfortunate. It is unfortunate that this bill has been brought up in a way that makes it impossible for our side to amend it.

Besides getting a vote on our bill, I was prepared to offer a series of amendments that focused on preventive care. I think if we are going to have a Health Week and we are going to have a bill, I want to start focusing on preventive care. We know it saves money. But we can't do that, either.

Count me as one who will not vote for cloture on this bill tomorrow, but count me as one who wants to have an open debate and amendment on a health insurance program that will be beneficial to our small businesses. I am sorry we are not going to be able to do it now.

Again, we are supposed to have a Health Week. Yet tomorrow I guess we will take all day tomorrow talking about the tax reconciliation bill, and then we are not going to be here Friday. What kind of Health Week is this? What kind of Health Week is it when we are not allowed to offer amendments and debate preventive health care, offer a different bill for the one before us?

I think the small business owners of America now know what is going on. I have heard from some who basically have been supportive of S. 1955 and they are backing off of it. They are saying no, we would rather have your bill, we would rather have the one that provides us with some tax credits so we can go out and join a bigger pool like the Federal Employees Health Benefit Program; so we can join a big pool and we can have preventive services; we can have the State mandates that are there now that cover quality. They would rather have that bill.

But I am sorry we probably will not be able to get it done this year and I think, as I said, that is not just unfortunate for us—heck, we have the best health care coverage. We have great health care coverage. The health coverage we have ought to be available to every American out there.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, one of the difficulties around here is the process we have to use. Another one is that nobody listens to anybody's debate. We have covered this in some detail earlier today, that relevant amendments would be accepted. The Durbin-Lincoln bill ought to be voted on. But it should not be voted on and then S. 1955 precluded from getting a vote. That is one of the possibilities in the organization and the rules that we have around here, that we could wind up voting on that one and skipping the vote on S. 1955 and saying: Look, all these people voted against that; that means they don't like health care for small business. But they wouldn't have gotten to vote for the one that they might have liked.

I went through a number of the reasons why S. 2510 has some problems. I object to people saying we ought to give everybody the same health care the Senators have. We ought to give them better health care than the Senators have. The only problem is we can't do either of those things. The bill that is on the floor by Durbin-Lincoln doesn't do either of those things. It is a different plan that uses kind of the same structure so we build the same kind of bureaucracy, except a lot bigger bureaucracy to handle all the people in America, and it limits all of the pools to each State because they will have to meet all of the mandates of each of those States instead of what we have in the Federal plan which is a national level of mandates.

We have our own level of mandates. We don't go by what the States do. But that is not what is in that bill. In that bill they would still have to go State by State, and if you go State by State, you can't form the kinds of pools that we need to be able to have the clout to negotiate a better price and to bring around the administration.

People say you want to get rid of mandates so that will save money. No. Every experiment, every minilab that has happened out there where small business people have been given the opportunity to band together and to do something, they have covered those mandates. They didn't give those mandates up.

How do you save money with this thing? Small businesses pay 35 percent for their administration. Big business, which we already excluded from all mandates, we excluded them from Federal control, we excluded them from State oversight and consumer protection, which is in my bill—it still has the State oversight and consumer protection in there—we gave the big businesses the wave on all of those things. They still kept the mandates. But where they saved the money is in administration. It costs them 8 percent to administer their plans. So 35 percent minus 8 percent means they save 27 percent over what a small businessman will do. And every 1 percent we can save on insurance brings 200,000 to 300,00 people back into the market.

That is why we want to have associations to be able to offer plans under State consumer protection, under the insurance commissioner's oversight.

But with some kind of a blended plan, they can cross State lines and have a uniform package, and they can have a big enough group so they can negotiate. That is what 1955 is about. We need to have a vote on that as well.

As far as mandates, Senator SNOWE is putting in a bill that will cover those basic things people are talking about.

The letter that the Senator read from—the American Diabetes Association—I talked about that a little bit earlier today. One of the difficulties we had in trying to do something with diabetes is that 42 States—it may even be 47 States—are doing something with diabetes, but no two do it alike.

Again, how do you blend across State boundaries unless you can get some kind of basic package? I know they will cover diabetes. Under the Snowe amendment, they will for sure.

The distressing part of their letter was, no matter what changes are made to the Enzi bill, defeat it. That is not a very reasonable approach by any disease group. That means that if I have an amendment that said find out everything that is done for diabetes and do everything for diabetes that is done anywhere, they would still be suggesting voting against my bill. I don't think that is a reasonable approach by any group.

The American Cancer Society wrote pretty much the same letter and said pretty much the same thing.

We are not trying to subtract, we are trying to add. We want people who are uninsured to come into the market, and we want people who already have insurance to be able to get more and better insurance for the same dollar. That is what employers are able to afford. We are trying to come up with a system such as that.

The only thing about filling the tree—which I agree with the Senator is gobbledygook—the only thing with that is to stick to small business health insurance.

There are another dozen things on insurance and health care that we ought to be debating. Each of them would take about 3 weeks to debate. At this point in the season, we are not going to get 3 weeks to debate anything. I am lucky to put together a few days to be able to talk about this. I hope to make more progress on that.

I have been working hard with everybody to try to come up with some kind of mechanism that will work. That is where we are on the bill. If we could do the things that are relevant to this, or also germane after cloture, then we could stay on the bill a little longer and keep working on it. If we don't get cloture, we are probably done with this discussion for the whole year. That will probably be the end of health care for the year. People have to keep that in mind when they are voting on cloture.

Even individual mandates can be brought up one at a time and put into the thing, or at least be voted on. The desire is not to keep votes from happening but to stick to small business health plans.

These folks have been asking us for 15 years for a change and some way to handle it. They have been encouraged several times because eight times the House has passed the association health plan. That was very exciting for them. They said I think we can get it. It never made it out of committee on the Senate side because there are some problems with the basic plan that the House passed.

When I got this chairmanship, I said we are going to do something to change this. We are going to find out what the objections are and see if there isn't a way to get something done that will get relief for the small businessman. The insurance companies were convinced that we were going to do something, so they sat down with me. The insurance commissioners had concerns, and they have always been one of the stakeholders. They sat down with me, and they had their representatives sit down with us days on end to work on some kind of a compromise. This is one.

Nobody is raving about it except the small businesses because they see it as an answer—not the final answer, not the total answer, but an answer—that moves closer to what they can afford to do. Again, it isn't by cutting mandates.

Mr. HARKIN. Mr. President, will the Senator yield?

Mr. ENZI. Yes.

Mr. HARKIN. He is a gentleman, and a good friend. I know he is serious about this because he is a small business owner himself.

As I said earlier—and I want to make sure we are clear—that under this gobbledygook, the filling of the tree—no one understands what we are talking about out there—because of the way the bill is laid down, the majority leader, under the rules of the Senate, today offered amendments to the bill so that we can't offer amendments. There is no way we can now offer amendments. If cloture is invoked tomorrow, then we have 30 hours on the bill, and that tree could stay filled. So we can never offer an amendment to this bill. We would then have a final vote on S. 1955 without being able to offer any amendments. Is that not so?

Mr. ENZI. Not quite.

Mr. HARKIN. Inform me.

Mr. ENZI. Even during the course of today and any other debate we have on this bill, we have said if there is a relevant amendment, we would consider taking that up and voting on it. One exception we have on that is the difficulty with Durbin-Lincoln. If we vote on that, that might be the only vote we ever get because the other side can block any further votes from happening because you would have to have unanimous consent to have a vote. So we would be blocked from ever having a vote on our bill.

Mr. HARKIN. That is the problem with this whole cloture process. Why didn't we try to reach a time agreement and an agreement on how many amendments would be offered? As I understand it, our side was willing to do that. Then we would not have this problem of cloture where we are precluded then from offering amendments.

As the Senator pointed out, if S. 2510 is offered, I don't know what would happen after that. The Senator said it wouldn't be offered. This whole thing with the cloture has screwed up everything.

Mr. ENZI. No, I wasn't suggesting that S. 2510 would pass. I was saying that a lot of Democrats would vote for it and it would fail. Then there will be no further votes on it. You folks could all say we voted for small business and the Republicans didn't vote for small business. It would be because the Republicans wanted S. 1955 with a few amendments which can be offered by both sides. That would happen postcloture. The only thing that happens postcloture is amendments have to be germane. That means they actually would have to apply to the bill. The Durbin-Lincoln bill is germane. Many of the things people talked about would be germane. What wouldn't be germane are some of the long-term debates and things people would like to do, namely the stem cell debate which we are going to have a debate on. They promised a vote on it. We don't know how much debate there would be with that; prescription drugs, Part D, and those would not be germane to the bill. Each of those would take about 3 weeks to debate.

Mr. HARKIN. I say to my friend, I think if agreements were made with this side and the other side, we could agree on time limits and structures without having this on us.

I also say to my friend, I think we should take 3 weeks to debate health care. We have been wasting so much time around here doing nothing. Now tomorrow we have tax reconciliation. So my friend from Wyoming is getting a day cut out of his deal. I think we ought to take 3 weeks to debate health care around here. It wouldn't bother me any.

Mr. ENZI. The Senator certainly is not the only one. I would love to have a lot of time. We have had a lot of bills that came out of committee already that could be brought up. We have some more that are going to come out next Tuesday. A lot of those I think would pass here by unanimous consent. I would love to have some agreement. The Senator knows how hard it is to get 1 week around here. We spent 3 days getting cloture to proceed. That is to proceed; that wasn't to actually do any votes on the bill. So we were offered the moment, but between the two sides we didn't get the moment.

Mr. HARKIN. I ask my friend, what was the vote on the motion to proceed?

Mr. ENZI. It was 98 to 2.

Mr. HARKIN. Then there was no problem with that.

Mr. ENZI. If there was no problem with it, why did we have to wait 3 days to get the vote?

Mr. HARKIN. We didn't have to wait 3 days to get the vote.

Mr. ENZI. I am talking about time limits and that sort of thing. Those requests were made between leaders to come up with some tight time agreements. It is beyond my pay grade.

Mr. HARKIN. It is beyond my pay grade, too. I wasn't involved in that.

Mr. ENZI. There were a lot negotiations to try to stick to small business and have some kind of a mechanism where the votes from both sides could be done. But there was not any agreement on that, so we are stuck in this kind of a situation where small business may be penalized once again.

Mr. HARKIN. That is a shame.

Mr. ENZI. If we get cloture, we could have a lot of debate on the small business stuff, not all of other ones. If we could get in a situation where we started doing these things a little quicker, with more time agreements, some of the more difficult ones could probably get some floor time. I am for that.

Mr. HARKIN. If we get cloture, we have 30 hours. Every Senator gets one 1 to speak. That is putting handcuffs on people; 30 hours, run the clock out. One person can get up and offer an amendment and that could be the only amendment we would have for that 30 hours. That is the way things work under cloture. It is not a good way to proceed. I think that is why some of us are upset. We want to help small business. I think there is a fair debate to be had between S. 1955 and S. 2510, with amendments. But somehow we are told that we are going to do this in 1 week. Monday is shot. We didn't do anything Monday. We had two votes Monday night. Tuesday, Wednesday, and then Thursday, tomorrow, is tax reconciliation. Health Week is 2 days. I don't think that is fair to small business, either. I think it is worth taking a couple of weeks around here to do it, and to do it right.

I thank the Senator for yielding.

Mr. ENZI. I am with the Senator.

Yes, it would be nice if we could wrap up something for small business. I think there is a plan there. I think there is a way to get there. I don't think it is going to happen without the cooperation of both sides in either coming to some time agreements or passing cloture.

We will have to wait and see what happens. I would wait until the end of next week to have a vote on either of them as long as we can do amendments. And I am excited about doing amendments. There are always perfecting things. No bill is perfect when we finish it. Even after conference it is never perfect. But it is usually much better than when we started. We need to have that process.

I thank everyone for their participation today.

Mr. FEINGOLD. Mr. President, I wish to speak today about the Medicare Prescription Drug Program. I opposed the final version of the legislation that created the Part D drug benefit, the Medicare Modernization Act, because I believed that it would not provide adequate relief for Medicare beneficiaries. I was concerned about the structure of the program, and worried that it would negatively affect Wisconsinites and other Americans who must quickly and affordably access prescription drugs. I have been trying to fix some of these problems since the program was enacted, but supporters of the program have been unwilling to consider these reforms. Instead, they have allowed these problems to remain, and the results, since the benefit was implemented in January, have been disastrous.

I have heard from a number of Wisconsinites who found the prescription drug plan enrollment process exceedingly confusing. Many people had difficulty finding a plan that would cover their prescriptions, while others could not get through to Medicare representatives to ask questions about the enrollment process. There have been breakdowns in the entire information process, and these failures by the insurance companies and the Centers for Medicare and Medicaid Services have sometimes completely blocked beneficiaries from accessing essential medications such as insulin, antipsychotics, and even immunosuppressants.

We can't afford to wait any longer in improving the Part D program so that it can better serve its beneficiaries. We need to minimize the negative effects of Part D's implementation problems and high costs. As part of this effort, I strongly support S. 1841, Senator BILL NELSON's, Medicare Informed Choice Act. This plan would allow beneficiaries extra time to navigate this confusing system by extending the enrollment period through the end of 2006. In addition, it would allow a one-time penalty-free change of programs for beneficiaries who have made a mistake in choosing their prescription drug plan.

Supporters of the Medicare prescription drug benefit have touted it as the vehicle that would supply affordable, easily accessible prescription drugs for seniors. The program has so far fallen far short of that goal. The outcry that I have heard from pharmacists, beneficiaries, and health care providers over the past couple months makes clear that the implementation of the program has been a disaster. This program has not provided either affordable or easily accessed drugs to many Medicare beneficiaries. Instead it has presented providers and beneficiaries with frustration, confusion, expensive medications, and sometimes no medications at all. It is unacceptable for individuals to go without life saving medications. Yet this is what has been happening in Wisconsin and across the country since this program commenced.

Since the beginning of January, I have received panicked phone calls from people in my State saying they were unable to receive drugs that they had been routinely getting at their pharmacy every other month. At the same time as I was hearing from people suffering from pain because they did not receive their pain medications, I read press releases from the Centers for Medicare and Medicaid that expressed satisfaction with the launch of the program, and boasted of the millions of participants in the program. There may be millions participating in the program, but too many of them cannot receive their drugs and too many pharmacists are unable to comply with the complicated regulations in the program. CMS should be focusing its efforts on addressing this emergency rather than disseminating public relations messages.

I have written Secretary Leavitt and Dr. McClellan repeatedly to express my concerns about Medicare Part D, including the approaching deadline. I hope that the administration will soon realize that it cannot continue to ignore these problems or hope they go away on their own, and that significant changes in the program are needed to better serve beneficiaries. I think it is time that CMS remember who this plan is supposed to serve: the people, not the drug and insurance companies.

We cannot sustain a great nation if we do not care for our elderly, sick, disabled, and home-bound. These are the people this drug plan is supposed to be serving, but they have been dismally let down. Let us make a simple change to the drug plan that will provide immense help to this group—extend the May 15 deadline. I urge the majority leader to bring up S. 1841 for a vote before the deadline passes.

Mr. OBAMA. Mr. President, over the past year and a half, I have spent a few days every month holding townhall meetings around my home State of Illinois. I have now done almost 50 of these in cities and towns all over the State.

After I give a short presentation, I open the floor to questions from the audience. And without fail, one of the first questions asked at every townhall is about health care. Too many hard-working Americans can't afford their medical bills or health insurance premiums. Too many employers are finding it difficult to offer the coverage their employees need. And sadly, too many people in the world's wealthiest country have no insurance at all.

When Senator FRIST declared the second week in May as ''Health Week,'' I naively assumed that maybe, just maybe, we would actually begin a real discussion about health care in the United States. I thought we would talk about serious and meaningful ways to address the health care problems faced by average Americans—important problems like: the 45 million Americans without health insurance; the worsening epidemic of chronic diseases, including asthma, obesity, and diabetes; the persistent and pervasive problems with patient safety and health

care quality; or the status of emergency and pandemic avian flu preparedness.

I know that I am not the only Senator who has been disappointed. A number of my Democratic colleagues have mentioned other pressing, critical issues on the floor this week, including stem cells, the looming enrollment deadline for Medicare Part D, and drug importation.

Yet so far we have had only a sham discussion on medical malpractice, revisiting the same old bills that have been rejected in the past that do not represent any real attempt to compromise and find solutions to the problems that many of our doctors and patients face.

And now, the Senate has turned its attention to the Enzi small business health plan. I know that small businesses need help in providing health care coverage to their employees. Small businesses are paying the price for this Congress's refusal to seriously embrace comprehensive health care reform, to expand coverage and contain costs.

Yet this bill is not the solution, and it is not part of a solution. In fact, some have described it as the antisolution.

In my opinion, any health coverage reform bill that passes the Congress should meet, at a minimum, three criteria: First, it may sound crazy, but I think a health coverage bill should actually expand coverage. The Enzi bill has been estimated to expand coverage to less than 1 million of the 45 million uninsured Americans. This is laughable.

In fact, some States will actually see an increase in the number of uninsured. In New York, for instance, 28,000 people could lose their health insurance coverage because of this bill.

Second, a good health reform bill should ensure comprehensive, quality health care. Over 200 health professional and patient advocacy groups have expressed their opposition to this bill, because it will promote health plans that won't offer the basic health care services that we all depend upon and take for granted, such as maternity care, mental health services, diabetes care, dental care, and so forth.

I have rarely seen such a large number of groups come together as swiftly, as vociferously, and as united as these groups have been against this bill.

Third, a good health reform bill should have a positive effect on the health insurance market. Will the market be stabilized and strengthened, or will it be weakened and fragmented? Again, the Enzi bill does not pass muster. Over 40 attorneys general have expressed serious concerns about this bill's preemption of State protections and laws and its restrictions on State oversight and regulation.

This so-called health week makes a mockery of the efforts of those who are working to achieve real health care reform. While we in Congress are squandering precious time on this bill, our States are moving ahead, exerting leadership because Congress has failed to act.

Illinois is in the process of implementing a program called All Kids, which will ensure that every child in the State is covered by health insurance. And we all know that Massachusetts just passed a sweeping, universal health coverage bill, negotiated and passed in bipartisan fashion.

In contrast, the last major health insurance reform passed by Congress was in 1997, when the SCHIP program was created. Even though the number of uninsured has continued to rise, almost 10 years have gone by without a serious congressional effort to address this crisis.

This is wrong. The Durbin-Lincoln amendment, which I have cosponsored, is a good example of how we can meaningfully expand health coverage without sacrificing the quality of care received.

The central tenet of the amendment is that small business employees should have access to the same health insurance coverage that members of Congress and other Federal employees receive themselves.

The health care problems facing our country are serious ones, and the solutions will not be easy. But we need to have a serious debate about this issue—a debate that addresses the whole problem and isn't just about scoring political points in an election year.

The American people expect as much, and I hope this failed attempt at a ''health week'' is not the last chance we will have to talk about an issue that is the chief financial concern of millions upon millions of people in this country.

Mr. LEAHY. Mr. President, for all of the recent talk from the majority about up-or-down votes, and allegations of Democratic obstruction on amendments, I find it astounding that the Republican majority has locked up Senator ENZI's bill and will not allow amendments to be offered. We now face exactly the type of obstruction the majority has decried so loudly. On a bill for which Senator ENZI has urged full debate, the Republican majority has now decided the Senate and the American people we represent should not get the benefit of the full legislative process. For example, I am being prohibited from offering an amendment to help prevent medical malpractice insurers from bid rigging, price fixing, and other anticompetitive behavior that hurts doctors and patients. For another, we are prohibited from offering an amendment to extend the arbitrary deadline for seniors to sign up for prescription drug benefits without a penalty. Why not provide our seniors more time and assistance in examining the prescription drug provisions that have frustrated so many? Seniors did not grow up in the computer age and many are not trained accountants who can sift through the confusion. They should not be penalized by an arbitrary cutoff date which could easily be extended.

This week, the Senate has already refused to proceed to legislation that would have abridged our citizens' access to justice when they are injured by medical errors. Those bills purported to lower medical malpractice insurance costs when, in fact, it is not payouts that have led to rising insurance premiums. The Senate has done the right thing by rejecting these bills once again.

The debate that preceded the votes demonstrated that capping medical malpractice awards is not the way to lower insurance premiums, which we all agree are unfair to the men and women who devote their lives to the care of others. There can be no disagreement that exorbitant insurance costs make it harder for medical professionals to do their jobs. Health care providers, like all Americans, deserve fair treatment in the marketplace. We also know that the insurance marketplace is unique, because unlike other business interests, insurers are not subject to some of the most important Federal antitrust laws.

High malpractice insurance premiums are not the result of malpractice lawsuit verdicts. This myth has been repeatedly discredited. They are the result of investment decisions by the insurance companies and of business models geared toward ever-increasing profits. But an insurer that has made a bad investment, or that has experienced the same disappointments from Wall Street that so many Americans have, should not be able to recoup its losses from the doctors it insures. The insurance industry should have to bear the burdens of its own business model, just as the other businesses in the economy do.

High malpractice premiums for doctors can occur because there is nothing stopping insurers in a soft market from collectively raising rates and stifling competition. Any other business would be prohibited from this activity, and I have heard no arguments as to why the insurance industry should be treated differently. The insurance industry is special because it is exempt from most Federal antitrust laws. The McCarran-Ferguson Act permits insurance companies to operate without being subject to those laws, and our Nation's physicians and their patients have been the worse off for it. Using their exemption, insurers can collude to set rates, resulting in higher premiums than true competition would achieve—and because of this exemption, enforcement officials cannot investigate any such collusion. If Congress is serious about controlling rising premiums, we must objectively limit this broad exemption in the McCarran-Ferguson Act.

The amendment I wanted to propose modifies the McCarran-Ferguson Act with respect to medical malpractice insurance, and only for the most pernicious antitrust offenses: Price fixing, bid rigging, and market allocations.

Only those anticompetitive practices that most certainly will affect premiums are addressed. I am hard pressed to imagine how anyone could object to a prohibition on insurance carriers' fixing prices or dividing territories.

After all, the rest of our Nation's industries manage either to abide by these laws or suffer the consequences. If medical malpractice insurers are certain that malpractice lawsuits drive their rates, then there should be no reason to object to bringing their business within the reach of the same Federal laws that apply to all others.

Many State insurance commissioners police the industry well within the power they are accorded in their own laws, and some States have antitrust laws of their own that could cover some anticompetitive activities in the insurance industry. My proposal, which I wanted to offer, is a scalpel, not a saw. It would not affect regulation of insurance by State insurance commissioners and other State regulators.

But there is no reason to perpetuate a system in which Federal enforcers are precluded from prosecuting the most harmful antitrust violations just because they are committed by insurance companies.

This amendment is a carefully tailored solution to one critical aspect of the problem of excessive medical malpractice insurance rates. I am sorry that I was stopped by the Republican leadership and could not offer this narrowly drawn legislation as a positive step towards improving the American health care system, which would help ensure that doctors and patients are treated fairly.

Mr. KENNEDY. Mr. President, the Senate is currently considering legislation proposed by Senator ENZI that would profoundly change health care coverage. The proposal has been modified from the version approved by our committee.

It is important for the Senate to understand fully the impact that this legislation would have on millions of Americans. I have requested an analysis of this modified proposal from Professor Mila Kofman of the Georgetown University Health Policy Institute.

I ask unanimous consent to have this analysis printed in the RECORD.

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

GEORGETOWN UNIVERSITY,
May 10, 2006.

SENATOR EDWARD KENNEDY,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR KENNEDY: This is a response to your request for an analysis of the proposed rating structure in the Manager's Amendment to S. 1955. This also addresses your question on how the proposed amendment compares with the current NAIC model law on small group rating:.

In general, the proposed Manager's Amendment would not improve the bill. Under the new proposed rating structure there would be no new protections for consumers and a significant loss of existing state-based protections in the area of premiums. This loss of protections will adversely impact people with medical needs, older workers, and women of child-bearing years. This will also have a negative impact on ''micro'' groups (employers with fewer than 10 employees) because insurers will be allowed to charge these groups higher rates solely on the basis of the employer's size.

Here is a brief summary of how the proposed amendment would work:

Associations: The amendment clarifies that associations certified as small business health plans (by the U.S. Department of Labor under Title I of the bill) would enjoy a complete carve-out from small group rating state pools in both adopting and non-adopting states. Each certified association would be allowed to have their own premium rate not tied to the rest of the small group market. This would segment the small group market. Assuming associations attract healthy businesses (there are many ways that the bill would allow associations to ''cherry-pick'' healthy people), any restrictions on rates in the rest of the small group market would be undermined. Rates between association coverage and coverage outside the association could vary broadly. For a discussion of this, please see attached paper ''Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change.''

In adopting states, the bill clarifies that premiums within an association may vary using the same standards that would apply in small group market (see discussion below). This would be at least 500 percent variation in rates for businesses covered by the association or if the state allows, variations in rates could be even greater.

In non-adopting states, it is unclear whether the rating standards in the bill would even apply. If they apply. then a variation in premiums of 500 percent would be allowed for businesses covered by an association (so some employers would pay 5 times more than others for the same coverage within an association).

Small group market: In adopting states, insurers are required to vary rates by at least 500 percent (called ''total variation limit''). This means that states can allow insurers to have greater variations in rates. Using age. health, claims. and duration factors. variations of at least 300% are required. Note that insurers must use age, health, or both and may use duration and claims experience. The option is given to insurers. If a state wants to adopt this approach and become an ''adopting state.'' it must allow insurers to use age and health. This requirement essentially eliminates community rating and adjusted community rating by allowing insurers to adjust rates based on health. Allowable factors included in the 500 percent minimum required variation are: industry. geography. group size, participation rate, class of business. and wellness programs. Note that gender is not listed. The bill is unclear whether gender rating is prohibited or is added to the 500 percent variation.

At renewal, the same rules would apply. This means that premiums may increase at least by 500 percent if a smaIl business has high claims the year before.

In non-adopting states (generally states with greater protections for consumers). the language in the bill is ambiguous. The proposal says ''The plan may not vary premium rates by more than 500 percent].'' The term ''plan'' is not defined. If the term ''plan'' means an ''insurer,'' then one possible interpretation is that premium variations are limited to 500 percent (if insurers chose to follow this new tederal standard). What is clear. however, is that adjusted community rating and pure community rating would be preempted.

Renewal rates would limited to trend plus 15 percent to reflect claims of small business.

Importantly, in non-adopting states insurers would have a choice of whether to follow a state's existing laws or the new federal one. As a way of example, in DC, which has no rating laws, assuming DC chooses not to adopt the bill's rating structure and is therefore a non-adopting state. Insurers are not likely to use the rating restrictions in the bill.

The proposed rating structure varies significantly from the NAIC model law for small business health insurance premiums. By way of background. the National Association of Insurance Commissioners (NAIC) in the early 1990's adopted and since replaced a model law that provided for rate bands that permit premium variation up to 200 percent based on health status. The old model, which is the basis for the original bill, allowed further premium variation based on age, gender, industry, small business group size, geography, and family composition. Rates based on adjustments for these factors had to be actuarially justified but were not limited except for industry, which was limited to a 15 percent variation. The old NAIC model act permitted a wide variation in rates, allowing for a price difference of 26 to 1, or more. This means that for the same policy an insurer could charge a business or a person $100 per month or $2600 per month depending on risk and other factors. Higher rates under the model would be permitted as long as there was actuarial evidence to support wider variations.

Shortly after adopting its original model with rate bands, the NAIC replaced it with a model law for small groups that requires adjusted community rating, prohibiting premium surcharges based on health or other risk characteristics (like claims experience and durational rating). The current NAlC model act limits premium surcharges based on age to 200 percent; it prohihits insurers from varying small group premiums based on gender of people in the group or an employer's size. Today 12 states follow the current NAlC model act. Ten states require all insurers to use community rating or adjusted community rating for all small group policies. Two others, Michigan and Pennsylvania, require Blue Cross Blue Shield plans (their largest insurers) and HMOs to use adjusted community rating. The proposed amendment would preempt these state rating protections.

Please let me know if you need additional information. Thank you for the opportunity to address your questions.

Very truly yours,

MILA KOFMAN, J.D.,
Associate Research Professor.

CLOTURE MOTION

Mr. FRIST. Mr. President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the pending modified substitute amendment to Calendar No. 417, S. 1955, Health Insurance Marketplace Modernization and Affordability Act of 2005.

Bill Frist, Johnny Isakson, Sam Brownback, John Thune, Thad Cochran, Wayne Allard, John Ensign, Richard Shelby, Larry Craig, Ted Stevens,

John McCain, Lamar Alexander, Norm Coleman, Judd Gregg, John E. Sununu, Pat Roberts, Craig Thomas.

ORDER OF PROCEDURE

Mr. FRIST. Mr. President, I ask unanimous consent that on Thursday, May 11, immediately after the time for the two leaders, the Senate begin consideration of the conference report to accompany H.R. 4297, the Tax Relief Extension Reconciliation Act; provided further that 8 hours remain out of the statutory time limit and that it be equally divided. I further ask consent that following the vote on the adoption of the conference report, and notwithstanding rule XXII, there be 60 minutes of debate, equally divided, between the chairman and ranking member of the HELP Committee or their designees prior to a vote on the motion to invoke cloture on the modified substitute to S. 1955, the small business health plans bill, with no intervening action or debate, and the live quorum waived.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, may I inquire of the majority leader, at this point, are we closing down debate on this bill?

Mr. FRIST. Mr. President, through the Chair, on the small business reform bill, we will have 1 hour prior to the cloture vote. And during the day tomorrow, I expect people will be coming to the floor talking, as well, on small business health plans.

Mr. DURBIN. If I may ask through the Chair to the majority leader, as I understand the procedural position we are in, earlier today the majority leader filled the tree, as we say, to preclude any further amendments. And now, as I understand it, the majority leader has filed a cloture motion, which basically means we are going to bring this to a close without further amendments, without further debate, one up-or-down vote on cloture?

Mr. FRIST. That is correct. Someone could offer an amendment tomorrow prior to the cloture vote, if they so desire.

Mr. DURBIN. If I might ask the majority leader through the Chair, I asked earlier today if we would be allowed to bring up the stem cell research issue, which the majority leader has expressed his support of, and whether we could bring that up for a vote this week while we are on Health Care Week so we could address this issue of medical research.

I would like to ask the majority leader through the Chair if we could bring it up before cloture or after cloture?

Mr. FRIST. Mr. President, through the Chair, the interest in stem cells will be debated in the future, at a time that is mutually set by the Democratic leadership working with the Republican leadership. Stem cells can be discussed but will not be voted upon before this cloture motion.

Mr. DURBIN. I thank the majority leader.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

FINAL PASSAGE OF H.R. 4939

Mr. ENZI. Mr. President, I wanted to take this opportunity to discuss why I made the difficult decision to vote against H.R. 4939, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery.

The United States is involved in operations overseas while dealing with natural disasters such as Hurricanes Katrina and Rita. On May 4, 2006, I voted against a $109 billion spending bill that was $17 billion more than what the President originally requested. Of course, on occasion, times call for emergency spending, but this bill goes far beyond what anyone would call emergency spending.

Many items in this bill do not constitute ''emergency'' spending. The bill would funnel millions of dollars to a road in Hawaii, millions of dollars in grants for research not related to emergencies, and still millions more to subsidize the volunteer work program AmeriCorps. Are these projects necessary? Possibly, but they are not an ''emergency.'' These spending proposals should go through the annual authorization and appropriations process. Congress must tighten the definition of what qualifies as an emergency. The use of supplemental spending bills must be saved for the true emergencies. True emergency funding is being bogged down with nonessential projects that have no business being in an emergency supplemental spending bill.

We must not saddle our children, their children, and their children's children with debt that we incurred because we did not properly restrain our spending. My very first speech in the Senate Chamber was on the need for a balanced budget. In 1997, I said that the Federal Government must learn to live within its means. Without any restraint on spending, we are simply adding onto our Nation's enormous debt. Unfortunately, this is still true today.

I recently visited American troops stationed in Kuwait. I always have and will continue to support our troops. I appreciate the sacrifices they make and the sacrifices of the families, friends, businesses and communities they leave behind.

Our American service men and women should have the financial resources they need to fight this crucial war on terror. This bill should be about voting to provide financial stability that allows the U.S. Government to support our troops and our veterans into the future. It is unfortunate that other nonemergency spending projects made their way into an important bill that included vital funding for our troops. I wish that the Senate would have followed the President's proposal and only included funding for real emergencies.

HONORING OUR ARMED FORCES

LANCE CORPORAL STEPHEN R. BIXLER

Mr. LIEBERMAN. Mr. President, I rise today to pay tribute to LCpl Stephen R. Bixler of Suffield, CT.

Corporal Bixler, a member of the 2nd Reconnaissance Battalion, 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, NC, was killed in action on May 4 while conducting combat operations against enemy forces in Anbar Province, Iraq. He was struck while on foot patrol by an improvised explosive device on his second tour of duty in Iraq. Corporal Bixler is fondly remembered as a quiet but strong leader with strength of character and self-assurance unusual for someone of his age. As an Eagle Scout and former senior patrol leader in his Boy Scout troop, Corporal Bixler enjoyed helping others. He joined the Marines shortly after graduating from Suffield High School in 2003 and served in Haiti prior to his tour in Iraq. He was well received and respected when he proudly visited his high school, where he had been admired as he excelled at academics and athletics, to talk to students about his experiences. He was a true patriot and defender of our great Nation's principles of freedom of justice. Corporal Bixler served as an example of the potent American spirit, which permeates this Nation's history.

I am both proud and grateful that we have the kind of defender exemplified by Corporal Bixler serving in the Persian Gulf. Our Nation extends its heartfelt condolences to his family. To his father, Richard, his mother, Linda, and sister, Sandra, we extend our profound gratitude for sharing this outstanding Marine with us, and we offer our prayers and support.

STAFF SERGEANT MARK WALL

Mr. GRASSLEY. Mr. President, I rise today to honor the life of a truly brave American who has passed away while defending our country. SSG Mark Wall died April 27, 2006, in Mosul, Iraq, where he was serving his country as part of Operation Iraqi Freedom. Staff Sergeant Wall was assigned to C Company, 2nd Battalion, 1st Infantry regiment in Fort Wainwright, AK. He was deployed to Iraq in August of 2005 and served near Mosul. I would like to extend my deepest sympathies to his parents, Arthur and Helen Wall, his two brothers and his sister.