SA 3922. Mr. SALAZAR submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3923. Ms. STABENOW (for herself and Mr. LEVIN) submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3924. Ms. SNOWE (for herself, Mr. BYRD, Mr. TALENT, and Mr. DOMENICI) submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

## TEXT OF AMENDMENTS

**SA 3874.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

In section 2932(b)(2) of the Public Health Service Act (as added by section 301 of the bill), strike the second sentence.

**SA 3875.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

In section 103 of the bill, strike subsection (b).

**SA 3876.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

In section 802 of the Employee Retirement Incomes Security Act of 1974 (as added by section 101(a) of the bill) strike subsection (d).

In section 103 of the bill, strike subsection (b).

**SA 3877.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

In section 802 of the Employee Retirement Incomes Security Act of 1974 (as added by section 101(a) of the bill) strike subsection (d)(2).

Strike sections 2914, 2924, and 2934 of the Public Health Service Act (as added by sections 201 and 301 of the bill).

**SA 3878.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

In section 802 of the Employee Retirement Incomes Security Act of 1974 (as added by section 101(a) of the bill) strike subsection (d).

**SA 3879.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike sections 2912(b), 2913, 2914, 2923, 2924, 2933, and 2934 of the Public Health Service Act (as added by section 201 and amended by section 301 of the bill).

At the appropriate place in title XXIX of the Public Health Service Act (as added by section 201 and amended by section 301 of the bill), insert the following:

**"SEC. 29___. PRESERVING STATE AUTHORITY OVER HEALTH INSURANCE.**

''(a) FEDERAL RATING RULES.—

''(1) STATE OPTION TO ACCEPT OR REJECT.—A State may elect to adopt or reject the Model Small Group Rating Rules or the Transitional Small Group Rating Rules promulgated under section 2911(a).

''(2) NO FEDERAL PREEMPTION FOR NON-ADOPTING STATES.—In the case of any State that elects not to adopt the Model Small Group Rating Rules or the Transitional Small Group Rating Rules promulgated under section 2911(a), no provision of this Act shall be construed to—

''(A) preempt or supersede any law of such State; or

''(B) limit the ability of such State to enforce any State law with respect to health insurance coverage.

''(b) FEDERAL BENEFIT CHOICE STANDARDS.—

''(1) STATE OPTION TO ACCEPT OR REJECT.—A State may elect to adopt or reject the Benefit Choice Standards promulgated under section 2922(a).

''(2) NO FEDERAL PREEMPTION FOR NON-ADOPTING STATES.—In the case of any State that elects not to adopt the Benefit Choice Standards promulgated under section 2922(a), no provision of this Act shall be construed to—

''(A) preempt or supersede any law of such State; or

''(B) limit the ability of such State to enforce any State law with respect to health insurance coverage.

''(c) FEDERAL HARMONIZATION STANDARDS.—

''(1) STATE OPTION TO ACCEPT OR REJECT.—A State may elect to adopt or reject the harmonized standards certified by the Secretary under section 2932(d).

''(2) NO FEDERAL PREEMPTION FOR NON-ADOPTING STATES.—In the case of any State that elects not to adopt the harmonized standards certified by the Secretary under section 2932(d), no provision of this Act shall be construed to—

''(A) preempt or supersede any law of such State; or

''(B) limit the ability of such State to enforce any State law with respect to health insurance coverage.

**SA 3880.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) increasing premiums for health insurance coverage for individuals with diabetes;

(2) permitting a health insurance issuer to deny coverage for medical items or services needed to treat, mitigate, or cure diabetes; or

(3) limiting the ability of a State to enforce State laws that prohibit premium increases or denials of coverage described in paragraphs (1) or (2);

shall not apply and shall not be enforced.

**SA 3881.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON PARTICIPATION.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), participation in small business health plans shall be limited to small employers (as defined for purposes of part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 101(a)).

**SA 3882.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. MODIFICATION OF REFERENCE TO NAIC MODEL RULES.**

Wherever in this Act (or an amendment made by this Act) there is a reference to the ''Adopted Small Employer Health Insurance Availability Model Act of 1993 of the National Association of Insurance Commissioners'' such reference shall be deemed to be the ''Adopted Small Employer Health Insurance Availability Model Act of 2000 of the

National Association of Insurance Commissioners''.

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**SA 3883.** Mr. VITTER (for himself and Mr. GRAHAM) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. GAO STUDY CONCERNING BENEFITS MANDATES.**

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Government Accountability Office shall complete a study, and submit to the Committee on Health, Education, Labor, and Pensions of the Senate, a report concerning certain health insurance benefits and services that are mandated by State laws and covered under small business health plans under this Act.

(b) PURPOSE.—The purpose of the study under subsection (a) shall be to compare benefits and services covered by small business health plans under this Act with benefits and services that are mandated by State laws.

(c) BENEFITS TO BE STUDIED.—For the purposes of this section, the benefits to be studies under the study under subsection (a) shall include—

(1) chiropractic coverage;

(2) mammography services;

(3) minimum hospital stays;

(4) secondary consultations for women who undergo mastectomies and lymph node dissections for breast cancer;

(5) bone density screenings;

(6) cervical cancer screenings;

(7) maternity care;

(8) well-baby care;

(9) immunizations;

(10) autism treatments and services;

(11) obesity coverage; and

(12) diabetes coverage.

(d) OTHER STUDY AREAS.—In conducting the study and submitting the report under subsection (a), the Government Accountability Office shall—

(1) consider the total number of small business health plans approved pursuant to this Act;

(2) include a summary of the 5 largest small business health plans, measured by the number of enrollees, which shall, with respect to each such plan, include—

(A) a list of all benefits covered;

(B) a list of States with residents covered under such plan; and

(C) a comparison of benefits covered under such plan with benefits mandated by the insurance laws of each State in which the plan is offered;

(3) for each of the benefits described in subsection (c), contain a list of the States that mandate such coverage; and

(4) for each of the benefits described in subsection (c), contain a description of the total number of small business health plans offering such benefit.

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**SA 3884.** Mr. VITTER submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. COUNTERFEIT-RESISTANT TECHNOLOGIES FOR PRESCRIPTION DRUGS.**

(a) REQUIRED TECHNOLOGIES.—The Secretary of Health and Human Services shall require that the packaging of any prescription drug incorporate—

(1) radio frequency identification (RFID) tagging technology, or similar trace and track technologies that have an equivalent function;

(2) tamper-indicating technologies; and

(3) blister security packaging when possible.

(b) USE OF TECHNOLOGIES.—

(1) AUTHORIZED USES.—The Secretary shall require that technologies described in subsection (a)(1) be used exclusively to authenticate the pedigree of prescription drugs, including by—

(A) implementing inventory control;

(B) tracking and tracing prescription drugs;

(C) verifying shipment or receipt of prescription drugs;

(D) authenticating finished prescription drugs; and

(E) electronically authenticating the pedigree of prescription drugs.

(2) PRIVACY PROTECTION.—The Secretary shall prohibit technologies required by subsection (a)(1) from containing or transmitting any information that may be used to identify a health care practitioner or the prescription drug consumer.

(3) PROHIBITION AGAINST ADVERTISING.—The Secretary shall prohibit technologies required by subsection (a)(1) from containing or transmitting any advertisement or information about prescription drug indications or off-label prescription drug uses.

(c) RECOMMENDED TECHNOLOGIES.—The Secretary shall encourage the manufacturers and distributors of prescription drugs to incorporate into the packaging of such drugs, in addition to the technologies required under subsection (a), overt optically variable counterfeit-resistant technologies that—

(1) are visible to the naked eye, providing for visual identification of prescription drug authenticity without the need for readers, microscopes, lighting devices, or scanners;

(2) are similar to technologies used by the Bureau of Engraving and Printing to secure United States currency;

(3) are manufactured and distributed in a highly secure, tightly controlled environment; and

(4) incorporate additional layers of nonvisible covert security features up to and including forensic capability.

(d) STANDARDS FOR PACKAGING.—

(1) MULTIPLE ELEMENTS.—For the purpose of making it more difficult to counterfeit the packaging of prescription drugs, the Secretary shall require manufacturers of prescription drugs to incorporate the technologies described in paragraphs (1), (2), and (3) of subsection (a), and shall encourage manufacturers and distributors of prescription drugs to incorporate the technologies described in subsection (c), into multiple elements of the physical packaging of the drugs, including—

(A) blister packs, shrink wrap, package labels, package seals, bottles, and boxes; and

(B) at the item level.

(2) LABELING OF SHIPPING CONTAINER.—Shipments of prescription drugs shall include a label on the shipping container that incorporates the technologies described in subsection (a)(1), so that members of the supply chain inspecting the packages will be able to determine the authenticity of the shipment. Chain of custody procedures shall apply to such labels and shall include procedures applicable to contractual agreements for the use and distribution of the labels, methods to audit the use of the labels, and database access for the relevant governmental agencies for audit or verification of the use and distribution of the labels.

(e) PENALTY.—A prescription drug is deemed to be misbranded for purposes of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) if the packaging or labeling of the drug is in violation of a requirement or prohibition applicable to the drug under subsection (a), (b), or (d).

(f) TRANSITIONAL PROVISIONS; EFFECTIVE DATES.—

(1) NATIONAL SPECIFIED LIST OF SUSCEPTIBLE PRESCRIPTION DRUGS.—

(A) INITIAL PUBLICATION.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish in the Federal Register a list, to be known as the National Specified List of Susceptible Prescription Drugs, consisting of not less than 30 of the prescription drugs that are most frequently subject to counterfeiting in the United States (as determined by the Secretary).

(B) REVISION.—Not less than annually through the end of calendar year 2009, the Secretary shall review and, as appropriate, revise the National Specified List of Susceptible Prescription Drugs. The Secretary may not revise the List to include fewer than 30 prescription drugs.

(2) EFFECTIVE DATES.—The Secretary shall implement the requirements and prohibitions of subsections (a), (b), and (d)—

(A) with respect to prescription drugs on the National Specified List of Susceptible Prescription Drugs, beginning not later than the earlier of—

(i) 1 year after the initial publication of such List; or

(ii) December 31, 2007; and

(B) with respect to all prescription drugs, beginning not later than December 31, 2010.

(3) AUTHORIZED USES DURING TRANSITIONAL PERIOD.—In lieu of the requirements specified in subsection (b)(1), for the period beginning on the effective date applicable under paragraph (2)(A) and ending on the commencement of the effective date applicable under paragraph (2)(B), the Secretary shall require that technologies described in subsection (a)(1) be used exclusively to verify the authenticity of prescription drugs.

(g) DEFINITIONS.—In this Act:

(1) The term ''pedigree''—

(A) means the history of each prior sale, purchase, or trade of the prescription drug involved to a distributor or retailer of the drug (including the date of the transaction and the names and addresses of all parties to the transaction); and

(B) excludes information about the sale, purchase, or trade of the drug to the drug consumer.

(2) The term ''prescription drug'' means a drug subject to section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)(1)).

(3) The term ''Secretary'' means the Secretary of Health and Human Services.

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**SA 3885.** Mr. BROWNBACK submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**TITLE ____—HEALTH RECORDS**

**SEC. ___01. SHORT TITLE.**

This title may be cited as the ''Independent Health Record Bank Act of 2006''.

**SEC. ___02. PURPOSES.**

It is the purpose of this title to provide for the establishment of a nationwide health information technology network to—

(1) improve healthcare quality, reduce medical errors, increase the efficiency of care, and advance the delivery of appropriate, evidence-based healthcare services;

(2) promotes the wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the healthcare needs of an individual;

(3) ensure that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location that the medical service involved is provided;

(4) produces greater value for healthcare expenditures by reducing healthcare costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in healthcare services;

(6) improve the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of healthcare information; and

(7) ensure that the confidentiality of individually identifiable health information of a patient is secure and protected.

**SEC. ___03. DEFINITIONS.**

In this title:

(1) ACCOUNT.—The term ''account'' means an electronic health record of an individual contained in an independent health record bank.

(2) ELECTRONIC HEALTH RECORD.—The term ''electronic health record'' means a longitudinal collection of personal health information concerning a single individual, entered or accepted by healthcare providers, and stored electronically.

(3) HEALTHCARE ENTITY.—The term ''healthcare entity'' includes healthcare consumers, providers, and payers, government agencies, pharmaceutical companies, laboratories, and research institutes.

(4) HIPAA.—The term ''HIPAA'' means the regulations under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

(5) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''individually identifiable health information'' has the meaning given such term in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)).

(6) NONIDENTIFIABLE HEALTH INFORMATION.—The term ''nonidentifiable health information'' means any list, description or other grouping of consumer information (including publicly available information pertaining to them) that is derived without using personally identifiable information that is not publicly available.

(7) PARTIALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''partially identifiable health information'' means any list, description, or other grouping of consumer information (and publicly available information pertaining to them) derived using any personally identifiable information that is not publicly available.

(8) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' shall have the meaning given such term for purposes of HIPAA.

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Commerce.

**SEC. ___04. INDEPENDENT HEALTH RECORD BANKS.**

(a) PURPOSE.—It is the purpose of this section to provide for the establishment of independent health record banks to achieve a savings of money and lives in the healthcare system through—

(1) the creation and storage of lifetime individual electronic health records for individuals that may contain health plan and debit card functionality and that serves the interests of all healthcare entities;

(2) the utilization of technological infrastructure with the goal of connecting health records to build a national health information network;

(3) the provision of health information data sets, within distinct authorization boundaries, based on usage needs, including—

(A) the sale of approved data for research and other consumer purposes as provided for under section ___06(b);

(B) the provision of data for emergency healthcare as provided for under section ___06(c); and

(C) the provision of data for all other healthcare needs determined appropriate by the Secretary (in accordance with the protections provided for under section ___06);

(4) the offering of incentives to employers that face rising employee health costs, to encourage employee participation in independent health record banks; and

(5) the creation of a source of tax-free income to support the operations of the independent health record banks, and, through revenue sharing, to provide incentives to independent health record bank account holders, healthcare providers, and fee payers to contribute health information.

(b) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall prescribe standards for the establishment and certification of independent health record banks to carry out the purposes described in subsection (a).

(2) REQUIREMENT OF NON-PROFIT ENTITY.—The standards under paragraph (1) shall permit a non-profit entity to establish an independent health record bank as a cooperative entity that operates for the benefit and in the interests of the membership of the bank as a whole. Such bank shall be owned and controlled by its members.

(3) FOR-PROFIT ENTITIES.—A for-profit entity may not participate in the establishment and operation of an independent health record bank, except to the extent that such entity is by contract employed to assist in carrying out the operations of the bank.

(4) TREATMENT AS COVERED ENTITY FOR PURPOSES OF HIPAA.—To the extent that an independent health record bank (or associated vendor) is engaged in transmitting protected health information, the bank shall be considered to be a covered entity for purposes of HIPAA with respect to such information.

(c) MEMBERSHIP.—

(1) IN GENERAL.—To be eligible to be a member of an independent health record bank, an individual shall obtain or have obtained a product or service from a covered entity that is to be used primarily for personal, family, or household purposes, or that individual's legal representative.

(2) NO LIMITATION ON MEMBERSHIP.—Nothing in this subsection shall be construed to permit an independent health record bank to restrict membership.

(d) RIGHTS RELATING TO INFORMATION IN THE BANK.—

(1) INDIVIDUAL CONSUMERS.—

(A) GENERAL RIGHT.—An individual who has a health record contained in an independent health record bank shall maintain ownership over the entire health record and shall have the right to review the contents of the record in its entirety at any time during the normal business operating hours of the bank.

(B) ADDITIONAL INFORMATION AND LIMITATION.—An individual described in subparagraph (A) may add personal health information to the health record of that individual, except that such individual shall not alter or falsify information that is entered into the health record by another healthcare entity. Such an individual shall have the right to propose an amendment to such information pursuant to standards prescribed by the Secretary relating to the correction of information contained in a health record.

(2) OTHER HEALTHCARE ENTITIES.—A healthcare entity (other than an individual) shall serve as the custodian of only that information that has been added by such entity to the health record of an individual that is maintained by an independent health record bank. Such entity may be permitted to have access to other specified information contained in such health record (including the entire record if appropriate) if such access is granted by the independent health record bank and the individual involved (pursuant to standards prescribed by the Secretary relating to access to information).

(e) FINANCING OF ACTIVITIES.—

(1) IN GENERAL.—An independent health record bank may generate revenue to pay for the operations of the bank through—

(A) charging healthcare entities, including individual account holders, account fees for use of the bank;

(B) the sale of nonidentifiable and partially identifiable health information contained in the bank for research purposes (as provided for in section ___06(b)); and

(C) the conduct of any other activities determined appropriate by the Secretary.

(2) SHARING OF REVENUE.—Revenue derived under paragraph (1)(B) shall be shared with independent health record bank account holders, and may be shared with healthcare providers and payers, in accordance with this title.

(3) TREATMENT OF INCOME.—For purposes of the Internal Revenue Code of 1986, any revenue described in this subsection shall not be included in gross income of any independent health record bank, independent health record bank account holder, healthcare provider, or payer described in this subsection.

**SEC. ___05. HEALTHCARE CLEARINGHOUSE ACTIVITIES.**

(a) APPLICATION OF SECTION.—This section shall apply to an independent health record bank (and associated vendors) with respect to activities undertaken by such bank in operating as a health care clearinghouse (as such term is defined in section 1171(2) of the Social Security Act (42 U.S.C. 1329d(2)).

(b) ACCREDITATION.—

(1) IN GENERAL.—To be eligible to carry out clearinghouse activities under this section, an independent health record bank (and associated vendors performing clearinghouse functions) shall be accredited by a national standards development organization, utilizing the criteria described in paragraph (2), that is properly authenticated and registered with the Attorney General and the Federal Trade Commission pursuant to the provisions of the National Cooperation Research and Production Act of 1993 (15 U.S.C. 4301 et seq.).

(2) CRITERIA.—The criteria to be used by a national standards development organization

in the accreditation of an independent health record bank under this section shall be designed to measure the competency, assets, practices, and procedures of the bank for purposes of conducting clearinghouse activities. Such criteria shall include—

(A) the technical capacity and electronic facilities of the bank for the receipt, transmission, and handling of electronic health information transactions;

(B) the ability of the bank to process transactions to which HIPAA applies;

(C) the backup and disaster recovery plans and capacity of the bank;

(D) the privacy practices, procedures, and employee training programs of the bank consistent with HIPAA; and

(E) the security practices, procedures, and employee training programs of the bank consistent with HIPAA, including compliance with the HIPAA security rule that protected health information must only be viewable by the intended recipient.

(3) EXISTING CLEARINGHOUSES.—An independent health record bank operated by an entity that has been certified under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) as a health care clearinghouse prior to the date of enactment of this Act shall be considered to be accredited for purposes of paragraph (1).

(c) INFORMATION REQUIREMENT.—An independent health record bank acting as a health care clearinghouse under this section shall ensure that reporting services are provided to individual consumers in a manner that includes the provision of lists of individuals or organizations that have accessed the health record account of the consumer or to whom health information disclosures concerning the consumer have been made in accordance with the requirements of HIPAA.

**SEC. ___06. AVAILABILITY AND USE OF HEALTHCARE INFORMATION IN BANK.**

(a) GENERAL RULE.—Except as provided in this section, access to specified sections of, or an entire, electronic health record maintained by an independent health record bank concerning an individual shall only be provided with the prior authorization of the individual involved, as authenticated as provided for under the standards prescribed by the Secretary under section ___08.

(b) AVAILABILITY OF DATA FOR RESEARCH AND OTHER ACTIVITIES.—An independent health record bank may sell nonidentifiable and partially identifiable health information concerning and individual only if—

(1) the bank and the individual involved agree to the sale;

(2) the agreement provided for under paragraph (1) includes parameters with respect to the disclosure of information involved and a process for the authorization of the further disclosure of partially identifiable health information;

(3) the data involved is to be used for research or other activities only as provided for in the agreement under paragraph (1);

(4) the data involved does not identify the individual who is the subject of the data;

(5) the revenue to be derived from the sale of the data is collected by the bank and equally divided between the bank and the individual involved, except that revenue may also be distributed to healthcare providers and payers as incentives to contribute additional data to the bank; and

(6) the transaction otherwise meets the requirements and standards prescribed by the Secretary.

(c) AVAILABILITY OF DATA FOR EMERGENCY HEALTHCARE.—

(1) FINDINGS.—Congress finds that—

(A) given the size and nature of visits to emergency departments in the United States, readily available health data could make the difference between life and death; and

(B) due to the case mix and volume of patients treated, emergency departments are well positioned to provide data for public health surveillance, community risk assessment, research, education, training, quality improvement, and other uses.

(2) USE OF DATA.—An independent health record bank may permit healthcare providers to access, during an emergency department visit, a limited, authenticated data set concerning an individual for emergency response purposes without the prior consent of the individual. Such limited data may include—

(A) patient identification data, as determined appropriate by the individual involved;

(B) provider identification that includes the use of a unique provider identifiers as provided for in section 1173 of the Social Security Act (42 U.S.C. 1320d-2);

(C) payment data;

(D) arrival and first assessment data;

(E) data related to the individual's vitals, allergies, and medication history;

(F) data related to existing chronic problems and active clinical conditions of the individual; and

(G) data concerning physical examinations, procedures, results, and diagnosis data relating to the visit.

(d) EFFECT ON HIPAA.—Nothing in this title shall be construed to affect the scope, substance, or applicability of the part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) or HIPAA as such relates to individually identifiable health information maintained in an independent health record bank.

**SEC. ___07. APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS.**

(a) IN GENERAL.—Existing Federal security and confidentiality standards and State security and confidentiality laws shall apply to this title (and the amendments made by this title) until such time as Congress acts to amend such standards.

(b) PROVISION OF INFORMATION AND INFORMATIONAL PROVISION.—

(1) DESIGNATION OF AGENCY.—Each State with an independent health records bank operating in the State shall designate a State agency to be responsible for addressing complaints by residents of the State with respect to health records contained in the bank.

(2) PROVISION OF INFORMATION.—An independent health record bank operating in a State shall provide the State authority designated under paragraph (1) with an informational filing that describes the policies of the bank, the types of information sold by the bank, and other relevant information determined appropriate by such authority.

(3) INFORMATION.—An individual who has a health record maintained by an independent health record bank shall direct any concerns, problems, or questions related to such record directly to the appropriate State authority.

(c) DEFINITIONS.—For purposes of this section:

(1) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term ''State security and confidentiality laws'' means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(2) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term ''current Federal security and confidentiality standards'' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 1173(d) of the Social Security Act.

(3) STATE.—The term ''State'' has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

**SEC. ___08. REGULATORY OVERSIGHT.**

(a) IN GENERAL.—In carrying out this title, the Secretary, acting through the Under Secretary for Technology or other appropriate official, shall—

(1) develop a program to certify entities to operate independent health record banks;

(2) provide assistance to encourage the growth of independent health record banks;

(3) track economic progress as it pertains to independent health records bank operators and individuals receiving non-taxable income with respect to accounts;

(4) conduct public education activities regarding the creation and usage of the independent health records banks;

(5) establish an interagency council under subsection (b) to develop standards for Federal security auditing for entities operating independent health record banks; and

(6) carry out any other activities determined appropriate by the Secretary.

(b) INTERAGENCY COUNCIL FOR SECURITY AUDITING.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services and other appropriate Federal officials, shall establish an interagency council to develop standards for Federal security auditing as it relates to data security, authentication, and authorization recommendations, and reviews of independent health record banks.

(2) DUTIES.—The interagency council established under paragraph (1) shall take into consideration the following factors when developing recommendations for security, authentication, and authorization of data in independent health record banks:

(A) The number and type of factors used for the exchange of protected health information.

(B) Requiring that individuals, who have health records that are maintained by the bank, be notified of a security breech with respect to such records, and any corrective action taken on behalf of the individual.

(C) Requiring that information sent to, or received from, an independent health record bank that has been designated as high-risk should be authenticated through the use of methods such as the periodic changing of passwords, the use of biometrics, the use of tokens or other technology as determined appropriate by the council.

(D) Recommendations for entities operating independent health record banks, including requiring analysis of the potential risk of health transaction security breeches based on set criteria.

(E) The conduct of audits of independent health record banks to ensure that they are in compliance with the requirements and standards established under this title.

(3) COMPLIANCE REPORT.—The interagency council established under this subsection shall annually submit to the Secretary a report on compliance by independent health record banks with the requirements and standard under this title. Such report shall be included in the report required under subsection (d).

(c) INTERAGENCY MEMORANDUM OF UNDERSTANDING.—The Secretary and the Secretary of Health and Human Services, and other Federal officials that may be impacted by this title, shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries or officials

relating to the same matter over which 2 or more such Secretaries or officials have responsibility under this title are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries or officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(d) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary, acting through the Under Secretary for Technology, shall submit to Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report that—

(1) describes individual owner or institution operator economic progress as achieved through independent health record bank usage and existing barriers to such usage;

(2) describes progress in security auditing as provided for by the interagency security council under subsection (b); and

(3) contains information on the other core responsibilities of the Secretary as described in subsection (a).

**SEC. ___09. PENALTIES FOR FRAUD AND ABUSE.**

The penalties provided for in section 1177(b) of the Social Security Act (42 U.S.C. 1320d-6) shall apply to the wrongful disclosure of information collected, maintained, or made available by an independent health record bank under this title, including disclosures by any employees or associates of any such bank or other healthcare entity using or disclosing such information.

**SEC. ___10. TAX CREDIT FOR EMPLOYER-PROVIDED EMPLOYEE INDEPENDENT HEALTH RECORD BANK ACCOUNT FEES.**

(a) ALLOWANCE OF CREDIT.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by adding at the end the following new section:

**''SEC. 45N. EMPLOYER-PROVIDED EMPLOYEE INDEPENDENT HEALTH RECORD BANK ACCOUNT FEES.**

''(a) DETERMINATION OF AMOUNT.—For purposes of section 38, the independent health record bank account investment credit determined under this section with respect to any taxpayer for any taxable year is an amount equal to the independent health record bank account investment provided by such taxpayer during the taxable year.

''(b) INDEPENDENT HEALTH RECORD BANK ACCOUNT INVESTMENT.—For purposes of this section, the term 'independent health record bank account investment' means, with respect to each employee of the taxpayer for any taxable year, an amount equal to the lesser of—

''(1) 50 percent of the cost for such employee to maintain an independent health record bank account paid by the taxpayer during the taxable year, or

''(2) $50.

''(c) INDEPENDENT HEALTH RECORD BANK ACCOUNT.—For purposes of this section, the term 'independent health record bank account' has the meaning given to the term 'account' under section ___03(1) of the Independent Health Record Bank Act of 2006.

''(d) SPECIAL RULES.—No deduction or credit (other than under this section) shall be allowed under this chapter with respect to any expense which is taken into account under subsection (a) in determining the credit under this section.

''(e) REPORTS.—

''(1) IN GENERAL.—Each taxpayer shall make such reports to the Secretary and to employees of the taxpayer regarding—

''(A) independent health record bank account investments made with respect to such employee during any calendar year, and

''(B) such other information as the Secretary may require.

''(2) TIME FOR MAKING REPORTS.—The reports required by this subsection—

''(A) shall be filed at such time and in such manner as the Secretary prescribes, and

''(B) shall be furnished to employees—

''(i) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(ii) in such manner as the Secretary prescribes.

''(f) REGULATIONS.—The Secretary may prescribe such regulations as may be necessary or appropriate to carry out this section.

''(g) APPLICATION OF SECTION.—This section shall apply with respect to any independent health record bank account investments made by the taxpayer for the 5-taxable year period beginning with the first taxable year during which such investments are made by the taxpayer.''.

(b) CREDIT TREATED AS BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''and'' at the end of paragraph (29), by striking the period at the end of paragraph (30) and inserting '', plus'', and by adding at the end the following new paragraph:

''(31) the independent health record bank account investment credit determined under section 45N(a).''.

(c) CONFORMING AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 45N. Employer-provided employee independent health record bank account fees.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(e) ADDITIONAL INCENTIVE FOR CONSUMERS PARTICIPATING IN IHRB.—Revenue generated by an independent health record bank and received by an account holder, healthcare entity, or healthcare payer shall not be considered taxable income under the Internal Revenue Code of 1986.

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**SA 3886.** Mr. FRIST proposed an amendment to the 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; as follows:

At the end of the modified amendment at the following;

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

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**SA 3887.** Mr. FRIST proposed an amendment to amendment SA 3886 proposed by Mr. FRIST to the 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; as follows:

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

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**SA 3888.** Mr. FRIST proposed an amendment to the 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; as follows:

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:

Sec. 1. Short title; table of contents; purposes.

TITLE I—SMALL BUSINESS HEALTH PLANS

Sec. 101. Rules governing small business health plans.

Sec. 102. Cooperation between Federal and State authorities.

Sec. 103. Effective date and transitional and other rules.

TITLE II—MARKET RELIEF

Sec. 201. Market relief.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

Sec. 301. Health Insurance Standards Harmonization.

(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.''.

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**SA 3889.** Mr. FRIST proposed an amendment to the 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; as follows:

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

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**SA 3890.** Mr. FRIST proposed an amendment to amendment SA 3889 proposed by Mr. FRIST to the 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; as follows:

At the end of the amendment add the following:

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

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**SA 3891.** Ms. COLLINS (for herself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROHIBITION ON DISCRIMINATION AGAINST HEALTH CARE PROVIDERS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), a health insurance issuer to which this Act (or amendment) applies shall comply with applicable State laws that prohibit discrimination with respect to participation, reimbursement, or indemnification under a health plan or other health insurance coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

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**SA 3892.** Ms. COLLINS (for herself and Mr. BINGAMAN) submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. DIABETES TREATMENT, EDUCATION, AND SUPPLIES.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), a health insurance issuer to which this Act (or amendment) applies shall comply with State laws that require coverage for diabetes treatment, education, supplies, and prescription drugs and biologics.

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**SA 3893.** Ms. COLLINS (for herself and Mr. FEINGOLD) submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. COVERAGE OF CERTAIN INJURIES SUSTAINED DURING LEGAL ACTIVITIES.**

(a) ERISA.—Section 702(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(3)) is amended—

(1) by striking ''CONSTRUCTION.—For'' and inserting the following: ''SCOPE.—

''(A) WAITING PERIODS.—For''; and

(2) by adding at the end the following:

''(B) LIMITATION ON DENIAL OF BENEFITS.—For purposes of paragraph (2), a group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not deny benefits otherwise provided under the plan or coverage for the treatment of an injury solely because such injury resulted from the participation of the individual in a legal mode of transportation or a legal recreational activity.''.

(b) PHSA.—Section 2702(a)(3) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(3)) is amended—

(1) by striking ''CONSTRUCTION.—For'' and inserting the following: ''SCOPE.—

''(A) WAITING PERIODS.—For''; and

(2) by adding at the end the following:

''(B) LIMITATION ON DENIAL OF BENEFITS.—For purposes of paragraph (2), a group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not deny benefits otherwise provided under the plan or coverage for the treatment of an injury solely because such injury resulted from the participation of the individual in a legal mode of transportation or a legal recreational activity.''.

(c) INTERNAL REVENUE CODE.—Section 9802(a)(3) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''CONSTRUCTION.—For'' and inserting the following: ''SCOPE.—

''(A) WAITING PERIODS.—For''; and

(2) by adding at the end the following:

''(B) LIMITATION ON DENIAL OF BENEFITS.—For purposes of paragraph (2), a group health plan may not deny benefits otherwise provided under the plan for the treatment of an injury solely because such injury resulted from the participation of the individual in a legal mode of transportation or a legal recreational activity.''.

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**SA 3894.** Ms. LANDRIEU submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. WAIVERS UNDER TITLE XXVI OF THE PUBLIC HEALTH SERVICE ACT FOR LOUISIANA FOR FISCAL YEARS 2007 AND 2008.**

(a) IN GENERAL.—For fiscal years 2007 and 2008, the Secretary of Health and Human Services shall waive the requirements of, with respect to Louisiana and any eligible metropolitan area in Louisiana, the following sections of the Public Health Service Act:

(1) Section 2611(b)(1) of such Act (42 U.S.C. 300ff–21(b)(1)).

(2) Section 2617(b)(6)(E) of such Act (42 U.S.C. 300ff–27(b)(6)(E)).

(3) Section 2617(d) of such Act (42 U.S.C. 300ff–27(d)).

(b) CONSEQUENCE OF WAIVER.—For fiscal years 2007 and 2008, the Secretary of Health and Human Services—

(1) may not prevent Louisiana or any eligible metropolitan area in Louisiana from receiving or utilizing, or both, funds granted or distributed, or both, pursuant to title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.) because of the failure of Louisiana or any eligible metropolitan area in Louisiana to comply with the requirements of the sections listed in paragraphs (1) through (3) of subsection (a);

(2) may not take action due to such noncompliance; and

(3) shall assess, evaluate, and review Louisiana or any eligible metropolitan area's eligibility for funds under such title XXVI as if Louisiana or such eligible metropolitan

area had fully complied with the requirements of the sections listed in paragraphs (1) through (3) of subsection (a).

(c) SUNSET OF WAIVER.—The waiver authority provided under subsection (a) shall apply for fiscal years 2007 and 2008 only. For fiscal year 2009 and each succeeding fiscal year, Louisiana and any eligible metropolitan area in Louisiana shall comply with each of the applicable requirements under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.).

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**SA 3895.** Ms. LANDRIEU submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. ELIGIBILITY OF HOSPITALS INCURRING HURRICANE-RELATED DAMAGE AND LOSSES FOR STAFFORD ACT RELIEF AND ASSISTANCE.**

(a) ELIGIBILITY OF HOSPITALS FOR RELIEF AND ASSISTANCE RELATED TO HURRICANES KATRINA AND RITA.—Notwithstanding sections 406(a)(1)(B) and 407(a)(2) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5172(a)(1)(B) and 42 U.S.C. 5173(a)(2)) or any other provision of such Act, any hospital that is located in a State for which the President has issued a declaration of major disaster with respect to Hurricane Katrina or Hurricane Rita shall be eligible for relief and assistance under title IV of such Act on the same terms and conditions as a hospital that is a private nonprofit facility.

(b) LIMITATION ON USE OF CERTAIN FUNDS BY HOSPITALS.—Notwithstanding section 406(c)(2)(B) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5172(c)(2)(B)), any in lieu contributions elected by a hospital eligible for such contributions pursuant to a declaration of major disaster referred to in subsection (a) may be used by the person owning or operating the hospital only for the purposes specified in such section and only in—

(1) the parish or county in which the hospital is located or was located;

(2) a parish or county that is contiguous to the parish or county referred to in paragraph (1); or

(3) a parish or county that is not more than 3 parishes or counties away from the parish or county referred to in paragraph (1).

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**SA 3896.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Responsible Public Readiness and Emergency Preparedness Act''.

**SEC. 2. REPEAL.**

The Public Readiness and Emergency Preparedness Act (division C of the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006 (Public Law 109-148)) is repealed.

**SEC. 3. NATIONAL BIODEFENSE INJURY COMPENSATION PROGRAM.**

(a) ESTABLISHMENT.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following:

''(q) BIODEFENSE INJURY COMPENSATION PROGRAM.—

''(1) ESTABLISHMENT.—There is established the Biodefense Injury Compensation Program (referred to in this subsection as the 'Compensation Program') under which compensation may be paid for death or any injury, illness, disability, or condition that is likely (based on best available evidence) to have been caused by the administration of a covered countermeasure to an individual pursuant to a declaration under subsection (p)(2).

''(2) ADMINISTRATION AND INTERPRETATION.—The statutory provisions governing the Compensation Program shall be administered and interpreted in consideration of the program goals described in paragraph (4)(B)(iii).

''(3) PROCEDURES AND STANDARDS.—The Secretary shall by regulation establish procedures and standards applicable to the Compensation Program that follow the procedures and standards applicable under the National Vaccine Injury Compensation Program established under section 2110, except that the regulations promulgated under this paragraph shall permit a person claiming injury or death related to the administration of any covered countermeasure to file either—

''(A) a civil action for relief under subsection (p); or

''(B) a petition for compensation under this subsection.

''(4) INJURY TABLE.—

''(A) INCLUSION.—For purposes of receiving compensation under the Compensation Program with respect to a countermeasure that is the subject of a declaration under subsection (p)(2), the Vaccine Injury Table under section 2114 shall be deemed to include death and the injuries, disabilities, illnesses, and conditions specified by the Secretary under subparagraph (B)(ii).

''(B) INJURIES, DISABILITIES, ILLNESSES, AND CONDITIONS.—

''(i) INSTITUTE OF MEDICINE.—Not later than 30 days after making a declaration described in subsection (p)(2), the Secretary shall enter into a contract with the Institute of Medicine, under which the Institute shall, within 180 days of the date on which the contract is entered into, and periodically thereafter as new information, including information derived from the monitoring of those who were administered the countermeasure, becomes available, provide its expert recommendations on the injuries, disabilities, illnesses, and conditions whose occurrence in one or more individuals are likely (based on best available evidence) to have been caused by the administration of a countermeasure that is the subject of the declaration.

''(ii) SPECIFICATION BY SECRETARY.—Not later than 30 days after the receipt of the expert recommendations described in clause (i), the Secretary shall, based on such recommendations, specify those injuries, disabilities, illnesses, and conditions deemed to be included in the Vaccine Injury Table under section 2114 for the purposes described in subparagraph (A).

''(iii) PROGRAM GOALS.—The Institute of Medicine, under the contract under clause (i), shall make such recommendations, the Secretary shall specify, under clause (ii), such injuries, disabilities, illnesses, and conditions, and claims under the Compensation Program under this subsection shall be processed and decided taking into account the following goals of such program:

''(I) To encourage persons to develop, manufacture, and distribute countermeasures, and to administer covered countermeasures to individuals, by limiting such persons' liability for damages related to death and such injuries, disabilities, illnesses, and conditions.

''(II) To encourage individuals to consent to the administration of a covered countermeasure by providing adequate and just compensation for damages related to death and such injuries, disabilities, illnesses, or conditions.

''(III) To provide individuals seeking compensation for damages related to the administration of a countermeasure with a non-adversarial administrative process for obtaining adequate and just compensation.

''(iv) USE OF BEST AVAILABLE EVIDENCE.—The Institute of Medicine, under the contract under clause (i), shall make such recommendations, the Secretary shall specify, under clause (ii), such injuries, disabilities, illnesses, and conditions, and claims under the Compensation Program under this subsection shall be processed and decided using the best available evidence, including information from adverse event reporting or other monitoring of those individuals who were administered the countermeasure, whether evidence from clinical trials or other scientific studies in humans is available.

''(v) APPLICATION OF SECTION 2115.—With respect to section 2115(a)(2) as applied for purposes of this subsection, an award for the estate of the deceased shall be—

''(I) if the deceased was under the age of 18, an amount equal to the amount that may be paid to a survivor or survivors as death benefits under the Public Safety Officers' Benefits Program under subpart 1 of part L of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796 et seq.); or

''(II) if the deceased was 18 years of age or older, the greater of—

''(aa) the amount described in subclause (I); or

''(bb) the projected loss of employment income, except that the amount under this item may not exceed an amount equal to 400 percent of the amount that applies under item (aa).

''(vi) APPLICATION OF SECTION 2116.—Section 2116(b) shall apply to injuries, disabilities, illnesses, and conditions initially specified or revised by the Secretary under clause (ii), except that the exceptions contained in paragraphs (1) and (2) of such section shall not apply.

''(C) RULE OF CONSTRUCTION.—Section 13632(a)(3) of Public Law 103–66 (107 Stat. 646) (making revisions by Secretary to the Vaccine Injury Table effective on the effective date of a corresponding tax) shall not be construed to apply to any revision to the Vaccine Injury Table made under regulations under this paragraph.

''(5) APPLICATION.—The Compensation Program applies to any death or injury, illness, disability, or condition that is likely (based on best available evidence) to have been caused by the administration of a covered countermeasure to an individual pursuant to a declaration under subsection (p)(2).

''(6) SPECIAL MASTERS.—

''(A) HIRING.—In accordance with section 2112, the judges of the United States Claims Court shall appoint a sufficient number of special masters to address claims for compensation under this subsection.

''(B) BUDGET AUTHORITY.—There are appropriated to carry out this subsection such sums as may be necessary for fiscal year 2006

and each fiscal year thereafter. This subparagraph constitutes budget authority in advance of appropriations and represents the obligation of the Federal Government.

''(7) COVERED COUNTERMEASURE.—For purposes of this subsection, the term 'covered countermeasure' has the meaning given to such term in subsection (p)(7)(A).

''(8) FUNDING.—Compensation made under the Compensation Program shall be made from the same source of funds as payments made under subsection (p).''.

(b) EFFECTIVE DATE.—This section shall take effect as of November 25, 2002 (the date of enactment of the Homeland Security Act of 2002 (Pub. L. 107–296; 116 Stat. 2135)).

**SEC. 4. INDEMNIFICATION FOR MANUFACTURERS AND HEALTH CARE PROFESSIONALS WHO ADMINISTER MEDICAL PRODUCTS NEEDED FOR BIODEFENSE.**

Section 224(p) of the Public Health Service Act (42 U.S.C. 233(p)) is amended—

(1) in the subsection heading by striking ''SMALLPOX'';

(2) in paragraph (1), by striking ''against smallpox'';

(3) in paragraph (2)—

(A) in the paragraph heading, by striking ''AGAINST SMALLPOX''; and

(B) in subparagraph (B), by striking clause (ii);

(4) by striking paragraph (3) and inserting the following:

''(3) EXCLUSIVITY; OFFSET.—

''(A) EXCLUSIVITY.—With respect to an individual to which this subsection applies, such individual may bring a claim for relief under—

''(i) this subsection;

''(ii) subsection (q); or

''(iii) part C.

''(B) ELECTION OF ALTERNATIVES.—An individual may only pursue one remedy under subparagraph (A) at any one time based on the same incident or series of incidents. An individual who elects to pursue the remedy under subsection (q) or part C may decline any compensation awarded with respect to such remedy and subsequently pursue the remedy provided for under this subsection. An individual who elects to pursue the remedy provided for under this subsection may not subsequently pursue the remedy provided for under subsection (q) or part C.

''(C) STATUTE OF LIMITATIONS.—For purposes of determining how much time has lapsed when applying statute of limitations requirements relating to remedies under subparagraph (A), any limitation of time for commencing an action, or filing an application, petition, or claim for such remedies, shall be deemed to have been suspended for the periods during which an individual pursues a remedy under such subparagraph.

''(D) OFFSET.—The value of all compensation and benefits provided under subsection (q) or part C of this title for an incident or series of incidents shall be offset against the amount of an award, compromise, or settlement of money damages in a claim or suit under this subsection based on the same incident or series of incidents.'';

(5) in paragraph (6)—

(A) in subparagraph (A), by inserting ''or under subsection (q) or part C'' after ''under this subsection''; and

(B) by redesignating subparagraph (B) as subparagraph (C);

(C) by inserting after subparagraph (A), the following:

''(B) GROSSLY NEGLIGENT, RECKLESS, OR ILLEGAL CONDUCT AND WILLFUL MISCONDUCT.—For purposes of subparagraph (A), grossly negligent, reckless, or illegal conduct or willful misconduct shall include the administration by a qualified person of a covered countermeasure to an individual who was not within a category of individuals covered by a declaration under subsection (p)(2) with respect to such countermeasure where the qualified person fails to have had reasonable grounds to believe such individual was within such a category.''; and

(D) by adding at the end the following:

''(D) LIABILITY OF THE UNITED STATES.—The United States shall be liable under this subsection with respect to a claim arising out of the manufacture, distribution, or administration of a covered countermeasure regardless of whether—

''(i) the cause of action seeking compensation is alleged as negligence, strict liability, breach of warranty, failure to warn, or other action; or

''(ii) the covered countermeasure is designated as a qualified anti-terrorism technology under the SAFETY Act (6 U.S.C. 441 et seq.).''

''(E) GOVERNING LAW.—Notwithstanding the provisions of section 1346(b)(1) and chapter 171 of title 28, United States Code, as they relate to governing law, the liability of the United States as provided in this subsection shall be in accordance with the law of the place of injury.

''(F) MILITARY PERSONNEL AND UNITED STATES CITIZENS OVERSEAS.—

''(i) MILITARY PERSONNEL.—The liability of the United States as provided in this subsection shall extend to claims brought by United States military personnel.

''(ii) CLAIMS ARISING IN A FOREIGN COUNTRY.—Notwithstanding the provisions of section 2680(k) of title 28, United States Code, the liability of the United States as provided for in the subsection shall extend to claims based on injuries arising in a foreign country where the injured party is a member of the United States military, is the spouse or child of a member of the United States military, or is a United States citizen.

''(iii) GOVERNING LAW.—With regard to all claims brought under clause (ii), and notwithstanding the provisions of section 1346(b)(1) and chapter 171 of title 28, United States Code, and of subparagraph (C), as they relate to governing law, the liability of the United States as provided in this subsection shall be in accordance with the law of the claimant's domicile in the United States or most recent domicile with the United States.''; and

(6) in paragraph (7)—

(A) by striking subparagraph (A) and inserting the following:

''(A) COVERED COUNTERMEASURE.—The term 'covered countermeasure', means—

''(i) a substance that is—

''(I)(aa) used to prevent or treat smallpox (including the vaccinia or another vaccine); or

''(bb) vaccinia immune globulin used to control or treat the adverse effects of vaccinia inoculation; and

''(II) specified in a declaration under paragraph (2); or

''(ii) a drug (as such term is defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act), biological product (as such term is defined in section 351(i) of this Act), or device (as such term is defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) that—

''(I) the Secretary determines to be a priority (consistent with sections 302(2) and 304(a) of the Homeland Security Act of 2002) to treat, identify, or prevent harm from any biological, chemical, radiological, or nuclear agent identified as a material threat under section 319F–2(c)(2)(A)(ii), or to treat, identify, or prevent harm from a condition that may result in adverse health consequences or death and may be caused by administering a drug, biological product, or device against such an agent;

''(II) is—

''(aa) authorized for emergency use under section 564 of the Federal Food, Drug, and Cosmetic Act, so long as the manufacturer of such drug, biological product, or device has—

''(AA) made all reasonable efforts to obtain applicable approval, clearance, or licensure; and

''(BB) cooperated fully with the requirements of the Secretary under such section 564; or

''(bb) approved or licensed solely pursuant to the regulations under subpart I of part 314 or under subpart H of part 601 of title 21, Code of Federal Regulations (as in effect on the date of enactment of the National Biodefense Act of 2005); and

''(III) is specified in a declaration under paragraph (2).''; and

(B) in subparagraph (B)—

(i) by striking clause (ii), and inserting the following:

''(ii) a health care entity, a State, or a political subdivision of a State under whose auspices such countermeasure was administered;'' and

(vi) in clause (viii), by inserting before the period ''if such individual performs a function for which a person described in clause (i), (ii), or (iv) is a covered person''.

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**SA 3897.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for All Act''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Medicare for all.
''TITLE XXII—MEDICARE FOR ALL
''Sec. 2201. Description of program.
''Sec. 2202. Eligibility, enrollment, and coverage.
''Sec. 2203. Benefits.
''Sec. 2204. Choice of coverage under private health care delivery systems.
''Sec. 2205. Medicare for All Trust Fund.
''Sec. 2206. Administration.
Sec. 3. Financing through employment tax.

**SEC. 2. MEDICARE FOR ALL.**

(a) ESTABLISHMENT OF PROGRAM.—The Social Security Act is amended by adding at the end the following:

''TITLE XXII—MEDICARE FOR ALL

**''SEC. 2201. DESCRIPTION OF PROGRAM.**

''The program under this title—

''(1) ensures that all Americans have high quality, affordable health care;

''(2) ensures that all Americans have access to health care as good as their Member of Congress receives; and

''(3) reduces the cost of health care and enhances American economic competitiveness in the global marketplace.

**''SEC. 2202. ELIGIBILITY, ENROLLMENT, AND COVERAGE.**

''(a) ELIGIBILITY.—

''(1) IN GENERAL.—Each eligible individual is entitled to benefits under the program under this title.

''(2) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—For purposes of this title, the term 'eligible individual' means an individual who—

''(i) is—

''(I) a citizen of the United States; or

''(II) a person who is lawfully present in the United States; and

''(ii) is not eligible for benefits under part A or B of title XVIII.

''(B) LAWFULLY PRESENT.—For purposes of subparagraph (A)(i)(II), a person is lawfully present in the United States if such person—

''(i) is described in section 431 of Public Law 104–193;

''(ii) is described in section 103.12 of title 8, Code of Federal Regulations (as in effect as of the date of enactment of the Medicare for All Act);

''(iii) is eligible to apply for employment authorization from the Department of Homeland Security as listed in section 274a.12 of title 8, Code of Federal Regulations (as in effect as of the date of enactment of the Medicare for All Act); or

''(iv) is otherwise determined to be lawfully present in the United States under criteria established by the Secretary, in consultation with the Secretary of Homeland Security.

''(3) PHASE-IN OF ELIGIBILITY.—Under rules established by the Secretary, eligibility for benefits under this title shall be phased-in as follows:

''(A) During the first 5 years the program under this title is in operation, eligible individuals who are under 20 years of age or who are over 55 years of age are eligible for such benefits.

''(B) During the second 5 years the program under this title is in operation, eligible individuals who are under 30 years of age or who are over 45 years of age are eligible for such benefits.

''(C) All eligible individuals are eligible for such benefits beginning with the eleventh year in which the program under this title is in operation.

''(4) ENSURING THAT ELIGIBLE INDIVIDUALS DO NOT AGE-OUT OF PROGRAM.—For purposes of subparagraphs (A) and (B) of paragraph (3)—

''(A) the determination of whether an eligible individual meets the age requirements under such subparagraphs shall be made on the date of enrollment in the program under this title; and

''(B) such an individual's enrollment under such program may not be terminated because the individual no longer meets such age requirements.

''(b) AUTOMATIC ENROLLMENT.—

''(1) IN GENERAL.—The Secretary shall establish a process under which each eligible individual is deemed to be enrolled under the program under this title. Such process shall include the following:

''(A) Deemed enrollment of an eligible individual upon birth in the United States.

''(B) Enrollment of eligible individuals at the time of immigration into the United States.

''(2) ISSUANCE OF CARD.—The Secretary shall provide for issuance of an appropriate card for individuals entitled to benefits under the program under this title. Not later than the sixth year the program under this title is in operation, the Secretary shall ensure that each such card is linked securely, and with strong privacy protections, to an electronic health record for each such individual. In order to accomplish such linkage, the Secretary is authorized to award grants, issue contracts, alter reimbursement under the program under this title, or provide such other incentives as are reasonable and necessary.

''(c) COVERAGE.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for coverage of benefits for items and services furnished on and after the date an individual is entitled to benefits under the program under this title.

''(2) INITIAL COVERAGE.—No coverage is available under the program under this title for items and services furnished before the date that is 18 months after the date of the enactment of the Medicare For All Act.

''(3) EXPIRATION OF COVERAGE.—An individual's coverage under the program under this title shall terminate as of the date the individual is no longer an eligible individual.

''(d) RELATION TO OTHER PROGRAMS.—

''(1) CONSTRUCTION.—

''(A) CONTINUED OPERATION OF PUBLIC PROGRAMS.—Nothing in this title shall be construed as requiring (or preventing) an individual who is entitled to benefits under the program under this title from obtaining benefits under any other public health care program to which the individual is entitled, including under a State Medicaid plan under title XIX, the State Children's Health Insurance Program under title XXI, a health program of the Department of Defense under chapter 55 of title 10, United States Code, a health program of the Department of Veterans Affairs under chapter 17 of title 38 of such Code, or a medical care program of the Indian Health Service or of a tribal organization.

''(B) CONTINUED OPERATION OF PRIVATE HEALTH INSURANCE.—Nothing in this title shall be construed as preventing an individual who is entitled to benefits under the program under this title from obtaining benefits that supplement or improve the benefits available under such program from any private health insurance plan or policy.

''(2) PRIMARY PAYOR; OTHER PUBLIC PROGRAMS PROVIDING WRAP AROUND BENEFITS.—The program under this title shall be primary payor to other public health care benefit programs and the benefits under such other public health care benefit programs shall supplement the benefits under the program under this title.

**''SEC. 2203. BENEFITS.**

''(a) COMPREHENSIVE BENEFIT PACKAGE.—The Secretary shall provide for benefits under the program under this title consistent with the following:

''(1) MEDICARE FEE-FOR-SERVICE BENEFITS.—The benefits include the full range and scope of benefits available under the original fee-for-service program under parts A and B of title XVIII.

''(2) PRESCRIPTION DRUG COVERAGE.—The benefits include coverage of prescription drugs at least as comprehensive as the prescription drug coverage offered as of January 1, 2006, under the Blue Cross/Blue Shield Standard Plan provided under the Federal employees health benefits program under chapter 89 of title 5, United States Code (in this title referred to as 'FEHBP'). Such coverage shall be administered in the same manner as other benefits under this section.

''(3) INCLUSION OF EPSDT.—The benefits include benefits for early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)) for individuals who are under the age of 21.

''(4) PARITY IN COVERAGE OF MENTAL HEALTH BENEFITS.—

''(A) IN GENERAL.—There shall not be any treatment limitations or financial requirements with respect to the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits. Nothing in this subparagraph shall be construed to require coverage for mental health benefits that are not medically necessary or to prohibit the appropriate medical management of such benefits.

''(B) RELATED DEFINITIONS.—For purposes of this paragraph—

''(i) FINANCIAL REQUIREMENTS.—The term 'financial requirements' includes deductibles, coinsurance, co-payments, other cost-sharing, and limitations on the total amount that may be paid by an individual with respect to benefits and shall include the application of annual and lifetime limits.

''(ii) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to services for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV–TR), or the most recent edition if different than the Fourth Edition, if such services are included as part of an authorized treatment plan that is in accordance with standard protocols and such services meet medical necessity criteria. Such term does not include benefits with respect to the treatment of substance abuse or chemical dependency.

''(iii) TREATMENT LIMITATIONS.—The term 'treatment limitations' means limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment under the qualifying health benefit plan.

''(5) PREVENTIVE SERVICES.—The benefits shall include coverage of such additional preventive health care items and services as the Secretary shall specify, in consultation with the United States Preventive Services Task Force.

''(6) HOME AND COMMUNITY BASED SERVICES.—The benefits shall include coverage of home and community-based services described in section 1915(c)(4)(B).

''(7) ADDITIONAL BENEFITS.—The benefits shall include such additional benefits that the Secretary determines appropriate.

''(8) REVISION.—Nothing in this subsection shall be construed as preventing the Secretary from improving the benefit package from time to time to account for changes in medical practice, new information from medical research, and other relevant developments in health science.

''(9) ADJUSTMENT AUTHORIZED.—The Secretary shall, on a regular basis, evaluate whether adding any of the benefits described in paragraphs (1) through (7) is necessary or advisable to promote the health of beneficiaries under the program under title XVIII. The Secretary is authorized to improve the benefits available under such program, based upon such evaluation.

''(b) COST-SHARING.—

''(1) IN GENERAL.—Except as otherwise provided under this subsection or subsection (a)(4), with respect to the benefits described in subsection (a)(1), such benefits shall be subject to the cost-sharing (in the form of deductibles, coinsurance, and copayments) and premiums applicable under the program described in such subsection.

''(2) PRESCRIPTION DRUG COVERAGE.—With respect to the benefits described in subsection (a)(2), such benefits shall be subject to the cost-sharing (in the form of deductibles, coinsurance, and copayments) applicable under the plan described in such subsection.

''(3) TREATMENT OF PREVENTIVE AND ADDITIONAL SERVICES.—With respect to benefits described in paragraphs (5) and (7) of subsection (a), such benefits shall be subject to cost-sharing (in the form of deductibles, coinsurance, and copayments) that is consistent (as determined by the Secretary) with the cost-sharing applicable under paragraph (1).

''(4) TREATMENT OF EPSDT AND HOME AND COMMUNITY-BASED SERVICES.—With respect to benefits described in paragraphs (3) and (6) of subsection (a), such benefits shall be subject to nominal cost-sharing (in the form of deductibles, coinsurance, and copayments)

that is consistent (as determined by the Secretary) with the cost-sharing applicable to such services under section 1916 (as in effect on January 1, 2006).

''(5) REDUCTION IN COST-SHARING FOR LOW-INCOME INDIVIDUALS.—The Secretary shall provide for reduced cost-sharing for low-income individuals in a manner that is no less protective than the reduced cost-sharing for individuals under section 1902(a)(10)(E) (as in effect on January 1, 2006).

''(c) FREEDOM TO CHOOSE YOUR OWN DOCTOR AND HEALTH PLAN.—Except in the case of individuals who elect enrollment in a private health plan under section 2204, the provisions of section 1802 shall apply under this title.

''(d) PAYMENT SCHEDULE.—

''(1) IN GENERAL.—The Secretary, with the assistance of the Medicare Payment Advisory Commission, shall develop and implement a payment schedule for benefits covered under the program under this title which are provided other than through private health plans. To the extent feasible, such payment schedule shall be consistent with comparable payment schedules and reimbursement methodologies applied to benefits provided under parts A and B of title XVIII, except, that with respect to the coverage of prescription drugs, the Secretary shall provide for payment in accordance with a payment schedule developed and implemented under the previous sentence.

''(2) ADDITIONAL PAYMENTS FOR QUALITY.—The Secretary shall establish procedures to provide reimbursement in addition to the reimbursement under paragraph (1) to health care providers that achieve measures (as established by the Secretary in consultation with health care professionals and groups representing eligible individuals) of health care quality. The Secretary shall ensure that such measures include measures of appropriate use of health information technology.

''(e) APPLICATION OF BENEFICIARY PROTECTIONS.—The Secretary shall provide for protections of beneficiaries under the program under this title that are not less than the beneficiary protections provided under title XVIII, including appeal rights and limitations on balance billing.

**''SEC. 2204. CHOICE OF COVERAGE UNDER PRIVATE HEALTH CARE DELIVERY SYSTEMS.**

''(a) IN GENERAL.—The Secretary shall provide a process for—

''(1) the offering of private health plans for the provision of benefits under the program under this title; and

''(2) the enrollment, disenrollment, termination, and change in enrollment of eligible individuals in such plans.

''(b) OFFERING OF PRIVATE HEALTH PLANS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified entities for the offering of private health plans under the program under this title. In entering into such contracts the Secretary shall have the same authority that the Director of the Office of Personnel Management has with respect to health benefits plans under FEHBP.

''(2) REQUIREMENTS.—The Secretary shall not enter into such a contract for the offering of a private health plan under the program under this title unless at least the following requirements are met:

''(A) BENEFITS AS GOOD AS YOUR CONGRESSMAN GETS.—Benefits under such plans are not less than the benefits offered to Members of Congress and Federal employees under FEHBP. Such plans may provide health benefits in addition to such required benefits and may impose a premium for the provision of benefits. Such plans may not provide for financial payments or rebates to enrollees.

''(B) BENEFICIARY PROTECTIONS.—Enrollees in such plans have beneficiary protections that are not less than the beneficiary protections applicable under this title to individuals not so enrolled and shall include beneficiary protections applicable under both FEHBP and part C of title XVIII.

''(C) OTHER ADMINISTRATIVE REQUIREMENTS.—The plans are subject to such requirements relating to licensure and solvency, protection against fraud and abuse, inspection, disclosure, periodic auditing, and administrative operations and efficiencies as the Secretary identifies, taking into account similar requirements under FEHBP and part C of title XVIII.

''(c) ANNUAL OPEN ENROLLMENT.—The process under subsection (a)(2) shall provide for an annual open enrollment period in which individuals may enroll, and change or terminate enrollment, in private health plans in a manner similar to that provided under FEHBP as of January 1, 2006.

''(d) PAYMENT TO PRIVATE HEALTH PLANS.—

''(1) IN GENERAL.—In the case of an individual enrolled in a private health plan under this section for a month, the Secretary shall provide for payment of an amount equal to 1/12 of the annual per capita amount (described in paragraph (2), as adjusted under paragraph (3)).

''(2) ANNUAL PER CAPITA AMOUNT.—The annual per capita amount under this paragraph shall be the annual average per capita cost of providing benefits under the program under this title (including both individuals enrolled and not enrolled under private health plan), as computed by the Secretary based on rules similar to the rules described in section 1876(a)(4).

''(3) RISK-ADJUSTMENT.—In making payment under this subsection, the Secretary shall apply risk adjustment factors similar to those applied to payments to Medicare Advantage organizations under section 1853, except that the Secretary shall ensure that payments under this subsection are adjusted based on such factors to ensure that the health status of the enrollee is reflected in such adjusted payments, including adjusting for the difference between the health status of the enrollee and individuals receiving benefits under the program under this title who are not so enrolled. Payments under this subsection must, in aggregate, reflect such differences.

''(e) REQUIREMENTS FOR FEHBP CARRIERS.—Each contract entered into or renewed under section 8902 of title 5, United States Code, shall require the carrier to offer a plan under this section on similar terms and conditions to the plan offered by the carrier under FEHBP.

**''SEC. 2205. MEDICARE FOR ALL TRUST FUND.**

''(a) ESTABLISHMENT OF TRUST FUND.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare for All Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

''(b) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Medicare for All Trust Fund, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to—

''(1) the taxes received in the Treasury under sections 1401(c), 3101(c), and 3111(c) of the Internal Revenue Code of 1986;

''(2) such portion of the taxes received in the Treasury under section 3201 as are attributable to the rate specified in section 3101(c) of such Code;

''(3) such portion of the taxes received in the Treasury under section 3211 of such Code as are attributable to the sum of the rates specified in section 3101(c) and 3111(c) of such Code; and

''(4) such portion of the taxes received in the Treasury under section 3221 as are attributable to the rate specified in section 3111(c) of such Code.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

''(c) INCORPORATION OF PROVISIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), subsections (b) through (i) of section 1817 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Hospital Insurance Trust Fund and part A of title XVIII, respectively.

''(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1817 under paragraph (1)—

''(A) any reference in such section to 'this part' is construed to refer to this title;

''(B) any reference to taxes referred to in subsection (a) of such section shall be construed to refer to the taxes referred to in subsection (b) of this section; and

''(C) the Board of Trustees of the Medicare for All Trust Fund shall be the same as the Board of Trustees of the Federal Hospital Insurance Trust Fund.

**''SEC. 2206. ADMINISTRATION.**

''Except as otherwise provided in this title—

''(1) the Secretary shall enter into appropriate contracts with providers of services, other health care providers, and medicare administrative contractors, taking into account the types of contracts used under title XVIII with respect to such entities, to administer the program under this title;

''(2) benefits described in section 2203 that are payable under the program under this title to such individuals shall be paid in a manner specified by the Secretary (taking into account, and based to the greatest extent practicable upon, the manner in which they are provided under title XVIII); and

''(3) provider participation agreements under title XVIII shall apply to enrollees and benefits under the program under this title in the same manner as they apply to enrollees and benefits under the program under title XVIII.''.

(b) CONFORMING AMENDMENTS TO SOCIAL SECURITY ACT PROVISIONS.—

(1) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended—

(A) by striking ''or the Federal Supplementary '' and inserting ''the Federal Supplementary''; and

(B) by inserting ''or the Medicare for All Trust Fund'' after ''such Trust Fund)''.

(2) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking ''and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII'' and inserting '', the Federal Supplementary Medical Insurance Trust Fund established by title XVIII, and the Medicare for All Trust Fund established under title XXII''.

(c) MAINTENANCE OF MEDICAID ELIGIBILITY AND BENEFITS.—In order for a State to continue to be eligible for payments under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) the State may not reduce standards of eligibility or benefits provided under its State Medicaid plan under title

XIX of the Social Security Act below such standards of eligibility and benefits in effect on the date of the enactment of this Act.

**SEC. 3. FINANCING THROUGH EMPLOYMENT TAX.**

(a) TAX ON EMPLOYEES.—Section 3101 of the Internal Revenue Code of 1986 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) MEDICARE FOR ALL.—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to 1.7 percent of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b)).''.

(b) TAX ON EMPLOYERS.—Section 3111 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) MEDICARE FOR ALL.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 7 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).''.

(c) TAX ON SELF-EMPLOYMENT.—Section 1401 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) MEDICARE FOR ALL.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the applicable percent of the self-employment income for such taxable year. For purposes of the preceding sentence, the applicable percent is a percent equal to the sum of the percent described in section 3101(c) plus the percent described in section 3111(c).''.

(d) RAILROAD RETIREMENT TAX.—

(1) TAX ON EMPLOYEES.—Section 3201(a) of such Code is amended by striking ''subsections (a) and (b) of section 3101'' and inserting ''subsections (a), (b), and (c) of section 3101''.

(2) TAX ON EMPLOYEE REPRESENTATIVES.—Section 3211(a) of such Code is amended by striking ''subsections (a) and (b) of section 3101 and subsections (a) and (b) of section 3111'' and inserting ''subsections (a), (b), and (c) of section 3101 and subsections (a), (b), and (c) of section 3111''.

(3) TAX ON EMPLOYERS.—Section 3221(a) of such Code is amended by striking ''subsections (a) and (b) of section 3111'' and inserting ''subsections (a), (b), and (c) of section 3111''.

(4) DETERMINATION OF CONTRIBUTION BASE.—Clause (iii) of section 3231(e)(2)(A) is amended to read as follows:

''(iii) HOSPITAL INSURANCE AND MEDICARE FOR ALL TAXES.—Clause (i) shall not apply to—

''(I) so much of the rate applicable under section 3201(a) or 3221(a) as does not exceed the sum of the rates of tax in effect under subsections (b) and (c) of section 3101, and

''(II) so much of the rate applicable under section 3211(a) as does not exceed the sum of the rates of tax in effect under subsections (b) and (c) of section 1401.''.

(e) APPLICATION OF TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.—Paragraphs (1) and (2) of section 3121(u) and section 3125(a) of such Code are each amended by striking ''sections 3101(b) and 3111(b)'' and inserting ''subsections (b) and (c) of section 3101 and subsections (b) and (c) of section 3111''.

(f) CONFORMING AMENDMENTS.—

(1) Section 1402(a)(12)(B) of such Code is amended by striking ''subsections (a) and (b) of section 1401'' and inserting ''subsections (a), (b), and (c) of section 1401''.

(2) Section 3121(q) of such Code is amended by striking ''subsections (a) and (b) of section 3111'' and inserting ''subsections (a), (b), and (c) of section 3111''.

(3) The last sentence of section 6051(a) of such Code is amended by striking ''sections 3101(c) and 3111(c)'' and inserting ''sections 3101(d) and 3111(d)''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to wages paid and self-employment income derived on or after January 1 of the year following the date of the enactment of this Act.

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**SA 3898.** Mr. KENNEDY submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**TITLE __—HEALTHY FAMILIES**

**SEC. __01. SHORT TITLE.**

This title may be cited as the ''Healthy Families Act''.

**SEC. __02. FINDINGS.**

Congress makes the following findings:

(1) Working Americans need to take time off for their own health care needs or to perform essential caretaking responsibilities for a wide range of family members, including, among others, their children, spouse, parents, and parents-in-law, and other children and adults for whom they are caretakers.

(2) Health care needs include preventive health care, diagnostic procedures, medical treatment, and recovery in response to short- and long-term illnesses and injuries.

(3) Providing employees time off to tend to their own health care needs ensures that they will be healthier in the long run. Preventive care helps avoid illnesses and injuries and routine medical care helps detect illnesses early and shorten the duration of illnesses.

(4) When parents are available to care for their children who become sick, children recover faster, more serious illnesses are prevented, and children's overall mental and physical health are improved. Parents who cannot afford to miss work and must send children with a contagious illness to child care or school contribute to the high rate of infections in child care centers and schools.

(5) Providing paid sick leave improves public health by reducing infectious disease. Policies that make it easier for sick adults and children to be isolated at home reduce the spread of infectious disease.

(6) Routine medical care results in savings by decreasing medical costs by detecting and treating illness and injury early, decreasing the need for emergency care. These savings benefit public and private payers of health insurance, including private businesses.

(7) The provision of individual and family sick leave by large and small businesses, both here in the United States and elsewhere, demonstrates that policy solutions are both feasible and affordable in a competitive economy. Measures that ensure that employees are both in good health themselves and do not need to worry about unmet family health problems help businesses by promoting productivity and reducing employee turnover.

(8) The American Productivity Audit found that presenteeism—the practice of employees coming to work despite illness—costs $180,000,000,000 annually in lost productivity. Studies in the Journal of Occupational and Environmental Medicine, the Employee Benefit News, and the Harvard Business Review show that presenteeism is a larger productivity drain than either absenteeism or short-term disability.

(9) The absence of sick leave has forced Americans to make untenable choices between needed income and jobs on the one hand and caring for their own and their family's health on the other.

(10) The majority of middle income Americans lack paid leave for self-care or to care for a family member. Low-income Americans are significantly worse off. Of the poorest families (the lowest quartile), 76 percent lack regular sick leave. For families in the next 2 quartiles, 63 percent and 54 percent, respectively lack regular sick leave. Even in the highest income quartile, 40 percent of families lack regular sick leave. Less than ½ of workers who have paid sick leave can use it to care for ill children.

(11) It is in the national interest to ensure that Americans from all demographic groups can care for their own health and the health of their families while prospering at work.

(12) Due to the nature of the roles of men and women in society, the primary responsibility for family caretaking often falls on women, and such responsibility affects the working lives of women more than it affects the working lives of men.

(13) Although women are still primarily responsible for family caretaking, an increasing number of men are taking on caretaking obligations, and men who request leave time for caretaking purposes are often denied accommodation or penalized because of stereotypes that caretaking is only ''women's work''.

(14) Employers' reliance on persistent stereotypes about the ''proper'' roles of both men and women in the workplace and in the home—

(A) creates a cycle of discrimination that forces women to continue to assume the role of primary family caregiver; and

(B) fosters stereotypical views among employers about women's commitment to work and their value as employees.

(15) Employment standards that apply to only one gender have serious potential for encouraging employers to discriminate against employees and applicants for employment who are of that gender.

**SEC. __03. PURPOSES.**

The purposes of this title are—

(1) to ensure that all working Americans can address their own health needs and the health needs of their families by requiring employers to provide a minimum level of paid sick leave including leave for family care;

(2) to diminish public and private health care costs by enabling workers to seek early and routine medical care for themselves and their family members;

(3) to accomplish the purposes described in paragraphs (1) and (2) in a manner that is feasible for employers; and

(4) consistent with the provision of the 14th amendment to the Constitution relating to equal protection of the laws, and pursuant to Congress' power to enforce that provision under section 5 of that amendment—

(A) to accomplish the purposes described in paragraphs (1) and (2) in a manner that minimizes the potential for employment discrimination on the basis of sex by ensuring generally that leave is available for eligible medical reasons on a gender-neutral basis; and

(B) to promote the goal of equal employment opportunity for women and men.

**SEC. __04. DEFINITIONS.**

In this title:

(1) CHILD.—The term ''child'' means a biological, foster, or adopted child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is—

(A) under 18 years of age; or

(B) 18 years of age or older and incapable of self-care because of a mental or physical disability.

(2) EMPLOYEE.—The term ''employee'' means an individual—

(A) who is—

(i)(I) an employee (including an applicant), as defined in section 3(e) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(e)), who is not covered under clause (v), including such an employee of the Library of Congress, except that a reference in such section to an employer shall be considered to be a reference to an employer described in clauses (i)(I) and (ii) of paragraph (3)(A); or

(II) an employee (including an applicant) of the Government Accountability Office;

(ii) a State employee (including an applicant) described in section 304(a) of the Government Employee Rights Act of 1991 (42 U.S.C. 2000e–16c(a));

(iii) a covered employee (including an applicant), as defined in section 101 of the Congressional Accountability Act of 1995 (2 U.S.C. 1301);

(iv) a covered employee (including an applicant), as defined in section 411(c) of title 3, United States Code; or

(v) a Federal officer or employee (including an applicant) covered under subchapter V of chapter 63 of title 5, United States Code; and

(B) who works an average of at least 20 hours per week or, in the alternative, at least 1,000 hours per year.

(3) EMPLOYER.—

(A) IN GENERAL.—The term ''employer'' means a person who is—

(i)(I) a covered employer, as defined in subparagraph (B), who is not covered under subclause (V);

(II) an entity employing a State employee described in section 304(a) of the Government Employee Rights Act of 1991;

(III) an employing office, as defined in section 101 of the Congressional Accountability Act of 1995;

(IV) an employing office, as defined in section 411(c) of title 3, United States Code; or

(V) an employing agency covered under subchapter V of chapter 63 of title 5, United States Code; and

(ii) is engaged in commerce (including government), in the production of goods for commerce, or in an enterprise engaged in commerce (including government) or in the production of goods for commerce.

(B) COVERED EMPLOYER.—

(i) IN GENERAL.—In subparagraph (A)(i)(I), the term ''covered employer''—

(I) means any person engaged in commerce or in any industry or activity affecting commerce who employs 15 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year;

(II) includes—

(aa) any person who acts, directly or indirectly, in the interest of an employer to any of the employees of such employer; and

(bb) any successor in interest of an employer;

(III) includes any ''public agency'', as defined in section 3(x) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(x)); and

(IV) includes the Government Accountability Office and the Library of Congress.

(ii) PUBLIC AGENCY.—For purposes of clause (i)(III), a public agency shall be considered to be a person engaged in commerce or in an industry or activity affecting commerce.

(iii) DEFINITIONS.—For purposes of this subparagraph:

(I) COMMERCE.—The terms ''commerce'' and ''industry or activity affecting commerce'' mean any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and include ''commerce'' and any ''industry affecting commerce'', as defined in paragraphs (1) and (3) of section 501 of the Labor Management Relations Act, 1947 (29 U.S.C. 142 (1) and (3)).

(II) EMPLOYEE.—The term ''employee'' has the same meaning given such term in section 3(e) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(e)).

(III) PERSON.—The term ''person'' has the same meaning given such term in section 3(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(a)).

(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(4) EMPLOYMENT BENEFITS.—The term ''employment benefits'' means all benefits provided or made available to employees by an employer, including group life insurance, health insurance, disability insurance, sick leave, annual leave, educational benefits, and pensions, regardless of whether such benefits are provided by a practice or written policy of an employer or through an ''employee benefit plan'', as defined in section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3)).

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means a provider who—

(A)(i) is a doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

(ii) is any other person determined by the Secretary to be capable of providing health care services; and

(B) is not employed by an employer for whom the provider issues certification under this title.

(6) PARENT.—The term ''parent'' means a biological, foster, or adoptive parent of an employee, a stepparent of an employee, or a legal guardian or other person who stood in loco parentis to an employee when the employee was a child.

(7) PRO RATA.—The term ''pro rata'', with respect to benefits offered to part-time employees, means the proportion of each of the benefits offered to full-time employees that are offered to part-time employees that, for each benefit, is equal to the ratio of part-time hours worked to full-time hours worked.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(9) SICK LEAVE.—The term ''sick leave'' means an increment of compensated leave provided by an employer to an employee as a benefit of employment for use by the employee during an absence from employment for any of the reasons described in paragraphs (1) through (3) of section __05(d).

(10) SPOUSE.—The term ''spouse'', with respect to an employee, has the meaning given such term by the marriage laws of the State in which the employee resides.

**SEC. __05. PROVISION OF PAID SICK LEAVE.**

(a) IN GENERAL.—An employer shall provide for each employee employed by the employer not less than—

(1) 7 days of sick leave with pay annually for employees working 30 or more hours per week; or

(2) a pro rata number of days or hours of sick leave with pay annually for employees working less than—

(A) 30 hours per week on a year-round basis; or

(B) 1,500 hours throughout the year involved.

(b) ACCRUAL.—

(1) PERIOD OF ACCRUAL.—Sick leave provided for under this section shall accrue as determined appropriate by the employer, but not on less than a quarterly basis.

(2) ACCUMULATION.—Accrued sick leave provided for under this section shall carry over from year to year, but this title shall not be construed to require an employer to permit an employee to accumulate more than 7 days of the sick leave.

(3) USE.—The sick leave may be used as accrued. The employer, at the discretion of the employer, may loan the sick leave to the employee in advance of accrual by such employee.

(c) CALCULATION.—

(1) LESS THAN A FULL WORKDAY.—Unless the employer and employee agree to designate otherwise, for periods of sick leave that are less than a normal workday, that leave shall be counted—

(A) on an hourly basis; or

(B) in the smallest increment that the employer's payroll system uses to account for absences or use of leave.

(2) VARIABLE SCHEDULE.—If the schedule of an employee varies from week to week, a weekly average of the hours worked over the 12-week period prior to the beginning of a sick leave period shall be used to calculate the employee's normal workweek for the purpose of determining the amount of sick leave to which the employee is entitled.

(d) USES.—Sick leave accrued under this section may be used by an employee for any of the following:

(1) An absence resulting from a physical or mental illness, injury, or medical condition of the employee.

(2) An absence resulting from obtaining professional medical diagnosis or care, or preventive medical care, for the employee subject to the requirement of subsection (e).

(3) An absence for the purpose of caring for a child, a parent, a spouse, or any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship, who—

(A) has any of the conditions or needs for diagnosis or care described in paragraph (1) or (2); and

(B) in the case of someone who is not a child, is otherwise in need of care.

(e) SCHEDULING.—An employee shall make a reasonable effort to schedule leave under paragraphs (2) and (3) of subsection (d) in a manner that does not unduly disrupt the operations of the employer.

(f) PROCEDURES.—

(1) IN GENERAL.—Paid sick leave shall be provided upon the oral or written request of an employee. Such request shall—

(A) include a reason for the absence involved and the expected duration of the leave;

(B) in a case in which the need for leave is foreseeable at least 7 days in advance of such leave, be provided at least 7 days in advance of such leave; and

(C) otherwise, be provided as soon as practicable after the employee is aware of the need for such leave.

(2) CERTIFICATION.—

(A) PROVISION.—

(i) IN GENERAL.—Subject to subparagraph (C), an employer may require that a request for leave be supported by a certification issued by the health care professional of the eligible employee or of an individual described in subsection (d)(3), as appropriate, if the leave period covers more than 3 consecutive workdays.

(ii) TIMELINESS.—The employee shall provide a copy of such certification to the employer in a timely manner, not later than 30 days after the first day of the leave. The employer shall not delay the commencement of

the leave on the basis that the employer has not yet received the certification.

(B) SUFFICIENT CERTIFICATION.—

(i) IN GENERAL.—A certification provided under subparagraph (A) shall be sufficient if it states—

(I) the date on which the leave will be needed;

(II) the probable duration of the leave;

(III) the appropriate medical facts within the knowledge of the health care provider regarding the condition involved, subject to clause (ii); and

(IV)(aa) for purposes of leave under subsection (d)(1), a statement that leave from work is medically necessary;

(bb) for purposes of leave under subsection (d)(2), the dates on which testing for a medical diagnosis or care is expected to be given and the duration of such testing or care; and

(cc) for purposes of leave under subsection (d)(3), in the case of leave to care for someone who is not a child, a statement that care is needed for an individual described in such subsection, and an estimate of the amount of time that such care is needed for such individual.

(ii) LIMITATION.—In issuing a certification under subparagraph (A), a health care provider shall make reasonable efforts to limit the medical facts described in clause (i)(III) that are disclosed in the certification to the minimum necessary to establish a need for the employee to utilize paid sick leave.

(C) REGULATIONS.—Regulations prescribed under section __13 shall specify the manner in which an employee who does not have health insurance shall provide a certification for purposes of this paragraph.

(D) CONFIDENTIALITY AND NONDISCLOSURE.—

(i) PROTECTED HEALTH INFORMATION.—Nothing in this title shall be construed to require a health care provider to disclose information in violation of section 1177 of the Social Security Act (42 U.S.C. 1320d–6) or the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d–2 note).

(ii) HEALTH INFORMATION RECORDS.—If an employer possesses health information about an employee or an employee's child, parent, spouse or other individual described in subsection (d)(3), such information shall—

(I) be maintained on a separate form and in a separate file from other personnel information;

(II) be treated as a confidential medical record; and

(III) not be disclosed except to the affected employee or with the permission of the affected employee.

(g) CURRENT LEAVE POLICIES.—

(1) EQUIVALENCY REQUIREMENT.—An employer with a leave policy providing paid leave options shall not be required to modify such policy, if such policy offers an employee the option, at the employee's discretion, to take paid sick leave that is at least equivalent to the sick leave described in paragraphs (1) and (2) of subsection (a) and subsection (d), or if the policy offers paid leave (in amounts equivalent to the amounts described in such paragraphs) for purposes that include the reasons described in subsection (d).

(2) NO ELIMINATION OR REDUCTION OF LEAVE.—An employer may not eliminate or reduce leave in existence on the date of enactment of this Act, regardless of the type of such leave, in order to comply with the provisions of this title.

**SEC. __06. POSTING REQUIREMENT.**

(a) IN GENERAL.—Each employer shall post and keep posted a notice, to be prepared or approved in accordance with procedures specified in regulations prescribed under section __13, setting forth excerpts from, or summaries of, the pertinent provisions of this title including—

(1) information describing leave available to employees under this title;

(2) information pertaining to the filing of an action under this title;

(3) the details of the notice requirement for foreseeable leave under section __05(f)(1)(B); and

(4) information that describes—

(A) the protections that an employee has in exercising rights under this title; and

(B) how the employee can contact the Secretary (or other appropriate authority as described in section __08) if any of the rights are violated.

(b) LOCATION.—The notice described under subsection (a) shall be posted—

(1) in conspicuous places on the premises of the employer, where notices to employees (including applicants) are customarily posted; or

(2) in employee handbooks.

(c) VIOLATION; PENALTY.—Any employer who willfully violates the posting requirements of this section shall be subject to a civil fine in an amount not to exceed $100 for each separate offense.

**SEC. __07. PROHIBITED ACTS.**

(a) INTERFERENCE WITH RIGHTS.—

(1) EXERCISE OF RIGHTS.—It shall be unlawful for any employer to interfere with, restrain, or deny the exercise of, or the attempt to exercise, any right provided under this title.

(2) DISCRIMINATION.—It shall be unlawful for any employer to discharge or in any other manner discriminate against (including retaliating against) any individual for opposing any practice made unlawful by this title, including—

(A) discharging or discriminating against (including retaliating against) any individual for exercising, or attempting to exercise, any right provided under this title;

(B) using the taking of sick leave under this title as a negative factor in an employment action, such as hiring, promotion, or a disciplinary action; or

(C) counting the sick leave under a no-fault attendance policy.

(b) INTERFERENCE WITH PROCEEDINGS OR INQUIRIES.—It shall be unlawful for any person to discharge or in any other manner discriminate against (including retaliating against) any individual because such individual—

(1) has filed an action, or has instituted or caused to be instituted any proceeding, under or related to this title;

(2) has given, or is about to give, any information in connection with any inquiry or proceeding relating to any right provided under this title; or

(3) has testified, or is about to testify, in any inquiry or proceeding relating to any right provided under this title.

(c) CONSTRUCTION.—Nothing in this section shall be construed to state or imply that the scope of the activities prohibited by section 105 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2615) is less than the scope of the activities prohibited by this section.

**SEC. __08. ENFORCEMENT AUTHORITY.**

(a) IN GENERAL.—

(1) DEFINITION.—In this subsection:

(A) the term ''employee'' means an employee described in clause (i) or (ii) of section __04(2)(A); and

(B) the term ''employer'' means an employer described in subclause (I) or (II) of section __04(3)(A)(i).

(2) INVESTIGATIVE AUTHORITY.—

(A) IN GENERAL.—To ensure compliance with the provisions of this title, or any regulation or order issued under this title, the Secretary shall have, subject to subparagraph (C), the investigative authority provided under section 11(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(a)), with respect to employees and employers.

(B) OBLIGATION TO KEEP AND PRESERVE RECORDS.—An employer shall make, keep, and preserve records pertaining to compliance with this title in accordance with section 11(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(c)) and in accordance with regulations prescribed by the Secretary.

(C) REQUIRED SUBMISSIONS GENERALLY LIMITED TO AN ANNUAL BASIS.—The Secretary shall not require, under the authority of this paragraph, an employer to submit to the Secretary any books or records more than once during any 12-month period, unless the Secretary has reasonable cause to believe there may exist a violation of this title or any regulation or order issued pursuant to this title, or is investigating a charge pursuant to paragraph (4).

(D) SUBPOENA AUTHORITY.—For the purposes of any investigation provided for in this paragraph, the Secretary shall have the subpoena authority provided for under section 9 of the Fair Labor Standards Act of 1938 (29 U.S.C. 209).

(3) CIVIL ACTION BY EMPLOYEES.—

(A) RIGHT OF ACTION.—An action to recover the damages or equitable relief prescribed in subparagraph (B) may be maintained against any employer in any Federal or State court of competent jurisdiction by one or more employees or their representative for and on behalf of—

(i) the employees; or

(ii) the employees and other employees similarly situated.

(B) LIABILITY.—Any employer who violates section __07 (including a violation relating to rights provided under section __05) shall be liable to any employee affected—

(i) for damages equal to—

(I) the amount of—

(aa) any wages, salary, employment benefits, or other compensation denied or lost to such employee by reason of the violation; or

(bb) in a case in which wages, salary, employment benefits, or other compensation have not been denied or lost to the employee, any actual monetary losses sustained by the employee as a direct result of the violation up to a sum equal to 7 days of wages or salary for the employee;

(II) the interest on the amount described in subclause (I) calculated at the prevailing rate; and

(III) an additional amount as liquidated damages; and

(ii) for such equitable relief as may be appropriate, including employment, reinstatement, and promotion.

(C) FEES AND COSTS.—The court in an action under this paragraph shall, in addition to any judgment awarded to the plaintiff, allow a reasonable attorney's fee, reasonable expert witness fees, and other costs of the action to be paid by the defendant.

(4) ACTION BY THE SECRETARY.—

(A) ADMINISTRATIVE ACTION.—The Secretary shall receive, investigate, and attempt to resolve complaints of violations of section __07 (including a violation relating to rights provided under section __05) in the same manner that the Secretary receives, investigates, and attempts to resolve complaints of violations of sections 6 and 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206 and 207).

(B) CIVIL ACTION.—The Secretary may bring an action in any court of competent jurisdiction to recover the damages described in paragraph (3)(B)(i).

(C) SUMS RECOVERED.—Any sums recovered by the Secretary pursuant to subparagraph (B) shall be held in a special deposit account

and shall be paid, on order of the Secretary, directly to each employee affected. Any such sums not paid to an employee because of inability to do so within a period of 3 years shall be deposited into the Treasury of the United States as miscellaneous receipts.

(5) LIMITATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an action may be brought under paragraph (3), (4), or (6) not later than 2 years after the date of the last event constituting the alleged violation for which the action is brought.

(B) WILLFUL VIOLATION.—In the case of an action brought for a willful violation of section __07 (including a willful violation relating to rights provided under section __05), such action may be brought within 3 years of the date of the last event constituting the alleged violation for which such action is brought.

(C) COMMENCEMENT.—In determining when an action is commenced under paragraph (3), (4), or (6) for the purposes of this paragraph, it shall be considered to be commenced on the date when the complaint is filed.

(6) ACTION FOR INJUNCTION BY SECRETARY.—The district courts of the United States shall have jurisdiction, for cause shown, in an action brought by the Secretary—

(A) to restrain violations of section __07 (including a violation relating to rights provided under section __05), including the restraint of any withholding of payment of wages, salary, employment benefits, or other compensation, plus interest, found by the court to be due to employees eligible under this title; or

(B) to award such other equitable relief as may be appropriate, including employment, reinstatement, and promotion.

(7) SOLICITOR OF LABOR.—The Solicitor of Labor may appear for and represent the Secretary on any litigation brought under paragraph (4) or (6).

(8) GOVERNMENT ACCOUNTABILITY OFFICE AND LIBRARY OF CONGRESS.—Notwithstanding any other provision of this subsection, in the case of the Government Accountability Office and the Library of Congress, the authority of the Secretary of Labor under this subsection shall be exercised respectively by the Comptroller General of the United States and the Librarian of Congress.

(b) EMPLOYEES COVERED BY CONGRESSIONAL ACCOUNTABILITY ACT OF 1995.—The powers, remedies, and procedures provided in the Congressional Accountability Act of 1995 (2 U.S.C. 1301 et seq.) to the Board (as defined in section 101 of that Act (2 U.S.C. 1301)), or any person, alleging a violation of section 202(a)(1) of that Act (2 U.S.C. 1312(a)(1)) shall be the powers, remedies, and procedures this title provides to that Board, or any person, alleging an unlawful employment practice in violation of this title against an employee described in section __04(2)(A)(iii).

(c) EMPLOYEES COVERED BY CHAPTER 5 OF TITLE 3, UNITED STATES CODE.—The powers, remedies, and procedures provided in chapter 5 of title 3, United States Code, to the President, the Merit Systems Protection Board, or any person, alleging a violation of section 412(a)(1) of that title, shall be the powers, remedies, and procedures this title provides to the President, that Board, or any person, respectively, alleging an unlawful employment practice in violation of this title against an employee described in section __04(2)(A)(iv).

(d) EMPLOYEES COVERED BY CHAPTER 63 OF TITLE 5, UNITED STATES CODE.—The powers, remedies, and procedures provided in title 5, United States Code, to an employing agency, provided in chapter 12 of that title to the Merit Systems Protection Board, or provided in that title to any person, alleging a violation of chapter 63 of that title, shall be the powers, remedies, and procedures this title provides to that agency, that Board, or any person, respectively, alleging an unlawful employment practice in violation of this title against an employee described in section __04(2)(A)(v).

**SEC. __09. GAO STUDY.**

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study to determine the following:

(1) The number of days employees used paid sick leave including—

(A) the number of employees who used paid sick leave annually;

(B) both the number of consecutive days, and total days, employees used paid sick leave for their illnesses, or illnesses of—

(i) a child;

(ii) a spouse;

(iii) a parent; or

(iv) any other individual; and

(C) the number of employees who used paid sick leave for leave periods covering more than 3 consecutive workdays.

(2) Whether employees used paid sick leave to care for illnesses or conditions caused by domestic violence against the employees or their family members.

(3) The cost to employers of implementing paid sick leave policies.

(4) The benefits to employers of implementing the policies, including improvements in retention and absentee rates and productivity.

(5) The cost to employees of providing certification issued by a health care provider to obtain paid sick leave.

(6) The benefits of paid sick leave to employees and their family members.

(7) Whether the provision of paid sick leave has affected the ability of employees to care for their family members.

(8) Whether and in what way the provision of paid sick leave affected the ability of employees to provide for their health needs.

(9) Whether the provision of paid sick leave affected the ability of employees to sustain an adequate income while meeting health needs of the employees and their family members.

(10) Whether employers who administered paid sick leave policies prior to the date of enactment of this Act were affected by the provisions of this title.

(11) Whether other types of leave were affected by this title including whether this title affected—

(A) paid vacation leave;

(B) paid family or medical leave; or

(C) personal leave.

(12) Whether paid sick leave affected retention and turnover.

(13) Whether paid sick leave increased the use of less costly preventive medical care and lowered the use of emergency room care.

(14) Whether paid sick leave reduced the number of children sent to school when the children were sick.

(15) Whether paid sick leave reduced the costs of presenteeism for employers.

(b) AGGREGATING DATA.—The data collected under paragraphs (1), (2), and (7) of subsection (a) shall be aggregated by gender, race, disability, earnings level, age, marital status, and family type, including parental status.

(c) REPORTS.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report to the appropriate committees of Congress concerning the results of the study conducted pursuant to subsection (a) and the data aggregated under subsection (b).

(2) FOLLOWUP REPORT.—Not later that 5 years after the date of enactment of this Act the Comptroller General of the United States shall prepare and submit a followup report to the appropriate committees of Congress concerning the results of the study conducted pursuant to subsection (a) and the data aggregated under subsection (b).

**SEC. __10. EFFECT ON OTHER LAWS.**

(a) FEDERAL AND STATE ANTIDISCRIMINATION LAWS.—Nothing in this title shall be construed to modify or affect any Federal or State law prohibiting discrimination on the basis of race, religion, color, national origin, sex, age, or disability.

(b) STATE AND LOCAL LAWS.—Nothing in this title shall be construed to supersede any provision of any State or local law that provides greater paid sick leave or other leave rights than the rights established under this title.

**SEC. __11. EFFECT ON EXISTING EMPLOYMENT BENEFITS.**

(a) MORE PROTECTIVE.—Nothing in this title shall be construed to diminish the obligation of an employer to comply with any contract, collective bargaining agreement, or any employment benefit program or plan that provides greater paid sick leave rights to employees than the rights established under this title.

(b) LESS PROTECTIVE.—The rights established for employees under this title shall not be diminished by any contract, collective bargaining agreement, or any employment benefit program or plan.

**SEC. __12. ENCOURAGEMENT OF MORE GENEROUS LEAVE POLICIES.**

Nothing in this title shall be construed to discourage employers from adopting or retaining leave policies more generous than policies that comply with the requirements of this title.

**SEC. __13. REGULATIONS.**

(a) IN GENERAL.—

(1) AUTHORITY.—Except as provided in paragraph (2), not later than 120 days after the date of enactment of this Act, the Secretary shall prescribe such regulations as are necessary to carry out this title with respect to employees described in clause (i) or (ii) of section __04(2)(A).

(2) GOVERNMENT ACCOUNTABILITY OFFICE; LIBRARY OF CONGRESS.—The Comptroller General of the United States and the Librarian of Congress shall prescribe the regulations with respect to employees of the Government Accountability Office and the Library of Congress, respectively.

(b) EMPLOYEES COVERED BY CONGRESSIONAL ACCOUNTABILITY ACT OF 1995.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the Board of Directors of the Office of Compliance shall prescribe (in accordance with section 304 of the Congressional Accountability Act of 1995 (2 U.S.C. 1384)) such regulations as are necessary to carry out this title with respect to employees described in section __04(2)(A)(iii).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this title except insofar as the Board may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

(c) EMPLOYEES COVERED BY CHAPTER 5 OF TITLE 3, UNITED STATES CODE.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the President (or the designee of the President) shall prescribe such regulations as are necessary to carry out this title with respect to employees described in section __04(2)(A)(iv).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this title except insofar as the President (or designee) may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

(d) EMPLOYEES COVERED BY CHAPTER 63 OF TITLE 5, UNITED STATES CODE.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the Director of the Office of Personnel Management shall prescribe such regulations as are necessary to carry out this title with respect to employees described in section __04(2)(A)(v).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this title except insofar as the Director may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

**SEC. __14. EFFECTIVE DATES.**

(a) IN GENERAL.—This title shall take effect 1 year after the date of issuance of regulations under section __13(a)(1).

(b) COLLECTIVE BARGAINING AGREEMENTS.—In the case of a collective bargaining agreement in effect on the effective date prescribed by subsection (a), this title shall take effect on the earlier of—

(1) the date of the termination of such agreement; or

(2) the date that occurs 18 months after the date of issuance of regulations under section __13(a)(1).

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**SA 3899.** Mr. DURBIN (for himself, Mrs. LINCOLN, Mr. REID, Mr. BAUCUS, Mr. KENNEDY, Mrs. CLINTON, Mr. KERRY, Mr. BINGAMAN, Ms. CANTWELL, Mr. PRYOR, Mr. HARKIN, Mr. OBAMA, Mr. LAUTENBERG, Mr. SCHUMER, Mr. KOHL, Mr. LIEBERMAN, Mr. DODD, Mr. DAYTON, Mr. JOHNSON, Mr. MENENDEZ, Mrs. BOXER, Mr. NELSON of Florda, Ms. MIKULSKI, Ms. STABENOW, Mr. CARPER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Small Employers Health Benefits Program Act of 2006''.

**SEC. 2. DEFINITIONS.**

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

(b) OTHER TERMS.—In this Act:

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

(2) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers who employed an average of at least 1 but not more than 100 employees on business days during the year preceding the date of application. Such term shall not include the Federal Government.

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

(4) OFFICE.—The term ''Office'' means the Office of Personnel Management.

(5) PARTICIPATING EMPLOYER.—The term ''participating employer'' means an employer that—

(A) elects to provide health insurance coverage under this Act to its employees; and

(B) is not offering other comprehensive health insurance coverage to such employees.

(c) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of subsection (b)(2):

(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence for the full year prior to the date on which the employer applies to participate, the determination of whether such employer meets the requirements of subsection (b)(2) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the employer's first full year.

(3) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(d) WAIVER AND CONTINUATION OF PARTICIPATION.—

(1) WAIVER.—The Office may waive the limitations relating to the size of an employer which may participate in the health insurance program established under this Act on a case by case basis if the Office determines that such employer makes a compelling case for such a waiver. In making determinations under this paragraph, the Office may consider the effects of the employment of temporary and seasonal workers and other factors.

(2) CONTINUATION OF PARTICIPATION.—An employer participating in the program under this Act that experiences an increase in the number of employees so that such employer has in excess of 100 employees, may not be excluded from participation solely as a result of such increase in employees.

(e) TREATMENT OF HEALTH BENEFITS PLAN AS GROUP HEALTH PLAN.—A health benefits plan offered under this Act shall be treated as a group health plan for purposes of applying the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) except to the extent that a provision of this Act expressly provides otherwise.

**SEC. 3. HEALTH INSURANCE COVERAGE FOR NON-FEDERAL EMPLOYEES.**

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

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

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

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

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

(3) any other change that would adversely affect the coverage afforded under such chapter 89 to employees and annuitants and members of family under that chapter.

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

(e) CONTRACTS FOR ADMINISTRATION.—The Office may enter into contracts for the performance of appropriate administrative functions under this Act.

(f) SEPARATE RISK POOL.—In the administration of this Act, the Office shall ensure that covered employees under this Act are in a risk pool that is separate from the risk pool maintained for covered individuals under chapter 89 of title 5, United States Code.

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

**SEC. 4. CONTRACT REQUIREMENT.**

(a) IN GENERAL.—The Office may enter into contracts with qualified carriers offering health benefits plans of the type described in section 8903 or 8903a of title 5, United States Code, without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to provide health insurance coverage to employees of participating employers under this Act. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Office shall ensure that health benefits coverage is provided for individuals only, individuals with one or more children, married individuals without children, and married individuals with one or more children.

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

(1) is licensed to offer health benefits plan coverage in each State in which the plan is offered; and

(2) meets such other requirements as determined appropriate by the Office.

(c) STATEMENT OF BENEFITS.—

(1) IN GENERAL.—Each contract under this Act shall contain a detailed statement of benefits offered and shall include information concerning such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(2) ENSURING A RANGE OF PLANS.—The Office shall ensure that a range of health benefits plans are available to participating employers under this Act.

(3) PARTICIPATING PLANS.—The Office shall not prohibit the offering of any health benefits plan to a participating employer if such plan is eligible to participate in the Federal Employees Health Benefits Program.

(4) NATIONWIDE PLAN.—With respect to all nationwide plans, the Office shall develop a benefit package that shall be offered in the case of a contract for a health benefit plan that is to be offered on a nationwide basis that meets all State benefit mandates.

(d) STANDARDS.—The minimum standards prescribed for health benefits plans under section 8902(e) of title 5, United States Code, and for carriers offering plans, shall apply to plans and carriers under this Act. Approval of a plan may be withdrawn by the Office only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

(e) CONVERSION.—

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

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

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

**SEC. 5. ELIGIBILITY.**

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

(1) is an employee of an employer described in section 2(b)(2), or is a self employed individual as defined in section 401(c)(1)(B) of the Internal Revenue Code of 1986; and

(2) is not otherwise enrolled or eligible for enrollment in a plan under chapter 89 of title 5, United States Code.

**SEC. 6. ALTERNATIVE CONDITIONS TO FEDERAL EMPLOYEE PLANS.**

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

(b) PREEXISTING CONDITION EXCLUSIONS.—

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

(2) EXCLUSION PERIOD.—A preexisting condition exclusion under this subsection shall provide for coverage of a preexisting condition to begin not later than 6 months after the date on which the coverage of the individual under a health benefits plan commences, reduced by the aggregate 1 day for each day that the individual was covered under a health insurance plan immediately preceding the date the individual submitted an application for coverage under this Act. This provision shall be applied notwithstanding the applicable provision for the reduction of the exclusion period provided for in section 701(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(3)).

(c) RATES AND PREMIUMS.—

(1) IN GENERAL.—Rates charged and premiums paid for a health benefits plan under this Act—

(A) shall be determined in accordance with this subsection;

(B) may be annually adjusted subject to paragraph (3);

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

(D) shall be adjusted to cover the administrative costs of the Office under this Act.

(2) DETERMINATIONS.—In determining rates and premiums under this Act, the following provisions shall apply:

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

(i) for the geographic area involved if the adjustment is based on geographical divisions that are not smaller than a metropolitan statistical area and the carrier provides evidence of geographic variation in cost of services;

(ii) based on whether such coverage is for an individual, two adults, one adult and one or more children, or a family; and

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

(B) LIMITATION.—Premium rates charged for coverage under this Act shall not vary based on health-status related factors, gender, class of business, or claims experience

(C) AGE ADJUSTMENTS.—

(i) IN GENERAL.—With respect to subparagraph (A)(iii), in making adjustments based on age, the Office shall establish no more than 5 age brackets to be used by the carrier in establishing rates. The rates for any age bracket may not vary by more than 50 percent above or below the community rate on the basis of attained age. Age-related premiums may not vary within age brackets.

(ii) AGE 65 AND OLDER.—With respect to subparagraph (A)(iii), a carrier may develop separate rates for covered individuals who are 65 years of age or older for whom medicare is the primary payor for health benefits coverage which is not covered under medicare.

''(3) READJUSTMENTS.—Any readjustment in rates charged or premiums paid for a health benefits plan under this Act shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the practice of the Office for the Federal Employees Health Benefits Program.

(d) TERMINATION AND REENROLLMENT.—If an individual who is enrolled in a health benefits plan under this Act terminates the enrollment, the individual shall not be eligible for reenrollment until the first open enrollment period following the expiration of 6 months after the date of such termination.

(e) CONTINUED APPLICABILITY OF STATE LAW.—

(1) HEALTH INSURANCE OR PLANS.—

(A) PLANS.—With respect to a contract entered into under this Act under which a carrier will offer health benefits plan coverage, State mandated benefit laws in effect in the State in which the plan is offered shall continue to apply.

(B) RATING RULES.—The rating requirements under subparagraphs (A) and (B) of subsection (c)(2) shall supercede State rating rules for qualified plans under this Act, except with respect to States that provide a rating variance with respect to age that is less than the Federal limit or that provide for some form of community rating.

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

(A) any State or local law or regulation except those laws and regulations described in subparagraph (B) of paragraph (1);

(B) any State grievance, claims, and appeals procedure law, except to the extent that such law is preempted under section 514 of the Employee Retirement Income Security Act of 1974; and

(C) State network adequacy laws.

(f) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to limit the application of the service-charge system used by the Office for determining profits for participating carriers under chapter 89 of title 5, United States Code.

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

(a) APPLICATION OF RISK CORRIDORS.—

(1) IN GENERAL.—This section shall only apply to carriers with respect to health benefits plans offered under this Act during any of calendar years 2007 through 2009.

(2) NOTIFICATION OF COSTS UNDER THE PLAN.—In the case of a carrier that offers a health benefits plan under this Act in any of calendar years 2007 through 2009, the carrier shall notify the Office, before such date in the succeeding year as the Office specifies, of the total amount of costs incurred in providing benefits under the health benefits plan for the year involved and the portion of such costs that is attributable to administrative expenses.

(3) ALLOWABLE COSTS DEFINED.—For purposes of this section, the term ''allowable costs'' means, with respect to a health benefits plan offered by a carrier under this Act, for a year, the total amount of costs described in paragraph (2) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such paragraph.

(b) ADJUSTMENT OF PAYMENT.—

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

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

(A) COSTS BETWEEN 103 AND 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Office shall reimburse the carrier for such excess costs through payment to the carrier of an amount equal to 75 percent of the difference between such allowable costs and 103 percent of such target amount.

(B) COSTS ABOVE 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are greater than 108 percent of the target amount for the plan and year, the Office shall reimburse the carrier for such excess costs through payment to the carrier in an amount equal to the sum of—

(i) 3.75 percent of such target amount; and

(ii) 90 percent of the difference between such allowable costs and 108 percent of such target amount.

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

(A) COSTS BETWEEN 92 AND 97 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the carrier shall be required to pay into the contingency reserve fund maintained under section 8909(b)(2) of title 5, United States Code, an amount equal to 75 percent of the difference between 97 percent

of the target amount and such allowable costs.

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

(i) 3.75 percent of such target amount; and

(ii) 90 percent of the difference between 92 percent of such target amount and such allowable costs.

(4) TARGET AMOUNT DESCRIBED.—

(A) IN GENERAL.—For purposes of this subsection, the term ''target amount'' means, with respect to a health benefits plan offered by a carrier under this Act in any of calendar years 2007 through 2011, an amount equal to—

(i) the total of the monthly premiums estimated by the carrier and approved by the Office to be paid for enrollees in the plan under this Act for the calendar year involved; reduced by

(ii) the amount of administrative expenses that the carrier estimates, and the Office approves, will be incurred by the carrier with respect to the plan for such calendar year.

(B) SUBMISSION OF TARGET AMOUNT.—Not later than December 31, 2006, and each December 31 thereafter through calendar year 2010, a carrier shall submit to the Office a description of the target amount for such carrier with respect to health benefits plans provided by the carrier under this Act.

(c) DISCLOSURE OF INFORMATION.—

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

(A) that a carrier offering a health benefits plan under this Act shall provide the Office with such information as the Office determines is necessary to carry out this subsection including the notification of costs under subsection (a)(2) and the target amount under subsection (b)(4)(B); and

(B) that the Office has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Office under such subsections.

(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Office only for the purposes of, and to the extent necessary in, carrying out this section.

**SEC. 8. ENCOURAGING PARTICIPATION BY CARRIERS THROUGH REINSURANCE.**

(a) ESTABLISHMENT.—The Office shall establish a reinsurance fund to provide payments to carriers that experience one or more catastrophic claims during a year for health benefits provided to individuals enrolled in a health benefits plan under this Act.

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

(1) a certification by the carrier that the carrier paid for at least one episode of care during the year for covered health benefits for an individual in an amount that is in excess of $50,000; and

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

(c) PAYMENT.—

(1) IN GENERAL.—The amount of a payment from the reinsurance fund to a carrier under this section for a catastrophic episode of care shall be determined by the Office but shall not exceed an amount equal to 80 percent of the applicable catastrophic claim amount.

(2) APPLICABLE CATASTROPHIC CLAIM AMOUNT.—For purposes of paragraph (1), the applicable catastrophic episode of care amount shall be equal to the difference between—

(A) the amount of the catastrophic claim; and

(B) $50,000.

(3) LIMITATION.—In determining the amount of a payment under paragraph (1), if the amount of the catastrophic claim exceeds the amount that would be paid for the healthcare items or services involved under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Office shall use the amount that would be paid under such title XVIII for purposes of paragraph (2)(A).

(d) DEFINITION.—In this section, the term ''catastrophic claim'' means a claim submitted to a carrier, by or on behalf of an enrollee in a health benefits plan under this Act, that is in excess of $50,000.

(e) TERMINATION OF FUND.—The reinsurance fund established under subsection (a) shall terminate on the date that is 2 years after the date on which the first contract period becomes effective under this Act.

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

Beginning on October 1, 2010, the Office may use amounts appropriated under section 14(a) that remain unobligated to establish a contingency reserve fund to provide assistance to carriers offering health benefits plans under this Act that experience unanticipated financial hardships (as determined by the Office).

**SEC. 10. EMPLOYER PARTICIPATION.**

(a) REGULATIONS.—The Office shall prescribe regulations providing for employer participation under this Act, including the offering of health benefits plans under this Act to employees.

(b) ENROLLMENT AND OFFERING OF OTHER COVERAGE.—

(1) ENROLLMENT.—A participating employer shall ensure that each eligible employee has an opportunity to enroll in a plan under this Act.

(2) PROHIBITION ON OFFERING OTHER COMPREHENSIVE HEALTH BENEFIT COVERAGE.—A participating employer may not offer a health insurance plan providing comprehensive health benefit coverage to employees other than a health benefits plan that—

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

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

(3) OFFER OF SUPPLEMENTAL COVERAGE OPTIONS.—

(A) IN GENERAL.—A participating employer may offer supplementary coverage options to employees.

(B) DEFINITION.—In subparagraph (A), the term ''supplementary coverage'' means benefits described as ''excepted benefits'' under section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

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

**SEC. 11. ADMINISTRATION THROUGH REGIONAL ADMINISTRATIVE ENTITIES.**

(a) IN GENERAL.—In order to provide for the administration of the benefits under this Act with maximum efficiency and convenience for participating employers and health care providers and other individuals and entities providing services to such employers, the Office is authorized to enter into contracts with eligible entities to perform, on a regional basis, one or more of the following:

(1) Collect and maintain all information relating to individuals, families, and employers participating in the program under this Act in the region served.

(2) Receive, disburse, and account for payments of premiums to participating employers by individuals in the region served, and for payments by participating employers to carriers.

(3) Serve as a channel of communication between carriers, participating employers, and individuals relating to the administration of this Act.

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

(5) The processing of grievances and appeals.

(b) APPLICATION.—To be eligible to receive a contract under subsection (a), an entity shall prepare and submit to the Office an application at such time, in such manner, and containing such information as the Office may require.

(c) PROCESS.—

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

(2) REQUIREMENT.—No contract shall be entered into with any entity under this section unless the Office finds that such entity will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Office finds pertinent.

(3) PUBLICATION OF STANDARDS AND CRITERIA.—The Office shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. In establishing such standards and criteria, the Office shall provide for a system to measure an entity's performance of responsibilities.

(4) TERM.—Each contract under this section shall be for a term of at least 1 year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term, except that the Office may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the entity involved as the Office may provide in regulations) if the Office finds that the entity has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the program established by this Act.

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

(1) a description of the duties of the contracting entity;

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

(3) an assurance that the entity will maintain such records and afford such access thereto as the Office finds necessary to assure the correctness and verification of the information and reports under paragraph (2) and otherwise to carry out the purposes of this Act;

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

(5) such other terms and conditions not inconsistent with this section as the Office may find necessary or appropriate.

**SEC. 12. COORDINATION WITH SOCIAL SECURITY BENEFITS.**

Benefits under this Act shall, with respect to an individual who is entitled to benefits under part A of title XVIII of the Social Security Act, be offered (for use in coordination with those medicare benefits) to the same extent and in the same manner as if coverage were under chapter 89 of title 5, United States Code.

**SEC. 13. PUBLIC EDUCATION CAMPAIGN.**

(a) IN GENERAL.—In carrying out this Act, the Office shall develop and implement an educational campaign to provide information to employers and the general public concerning the health insurance program developed under this Act.

(b) ANNUAL PROGRESS REPORTS.—Not later than 1 year and 2 years after the implementation of the campaign under subsection (a), the Office shall submit to the appropriate committees of Congress a report that describes the activities of the Office under subsection (a), including a determination by the office of the percentage of employers with knowledge of the health benefits programs provided for under this Act.

(c) PUBLIC EDUCATION CAMPAIGN.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2007 and 2008.

**SEC. 14. APPROPRIATIONS.**

There are authorized to be appropriated to the Office, such sums as may be necessary in each fiscal year for the development and administration of the program under this Act.

**SEC. 15. REFUNDABLE CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.**

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and inserting after section 35 the following new section:

**"SEC. 36. SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.**

''(a) DETERMINATION OF AMOUNT.—In the case of a qualified small employer, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the sum of—

''(1) the expense amount described in subsection (b), and

''(2) the expense amount described in subsection (c), paid by the taxpayer during the taxable year.

''(b) SUBSECTION (b) EXPENSE AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The expense amount described in this subsection is the applicable percentage of the amount of qualified employee health insurance expenses of each qualified employee.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

''(A) IN GENERAL.—The applicable percentage is equal to—

''(i) 25 percent in the case of self-only coverage,

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

''(iii) 30 percent in the case of coverage for two adults or one adult and one or more children.

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

''(c) SUBSECTION (c) EXPENSE AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The expense amount described in this subsection is, with respect to the first credit year of a qualified small employer which is an eligible employer, 10 percent of the qualified employee health insurance expenses of each qualified employee.

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

''(d) LIMITATION BASED ON WAGES.— With respect to a qualified employee whose wages at an annual rate during the taxable year exceed $25,000, the percentage which would (but for this section) be taken into account as the percentage for purposes of subsection (b)(2) or (c)(1) for the taxable year shall be reduced by an amount equal to the product of such percentage and the percentage that such qualified employee's wages in excess of $25,000 bears to $5,000.

''(e) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED SMALL EMPLOYER.—The term 'qualified small employer' means any employer (as defined in section 2(b)(2) of the Small Employers Health Benefits Program Act of 2006) which—

''(A) is a participating employer (as defined in section 2(b)(5) of such Act),

''(B) pays or incurs at least 60 percent of the qualified employee health insurance expenses of each qualified employee for self-only coverage, and

''(C) pays or incurs at least 50 percent of the qualified employee health insurance expenses of each qualified employee for all other categories of coverage.

''(2) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

''(A) IN GENERAL.—The term 'qualified employee health insurance expenses' means any amount paid by an employer for health insurance coverage under such Act to the extent such amount is attributable to coverage provided to any employee while such employee is a qualified employee.

''(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account under subparagraph (A).

''(3) QUALIFIED EMPLOYEE.—

''(A) DEFINITION.—

''(i) IN GENERAL.—The term 'qualified employee' means, with respect to any period, an employee (as defined in section 2(b)(1) of such Act) of an employer if the total amount of wages paid or incurred by such employer to such employee at an annual rate during the taxable year exceeds $5,000 but does not exceed $30,000.

''(ii) ANNUAL ADJUSTMENT.—For each taxable year after 2007, the dollar amounts specified for the preceding taxable year (after the application of this subparagraph) shall be increased by the same percentage as the average percentage increase in premiums under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code for the calendar year in which such taxable year begins over the preceding calendar year.

''(B) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(f) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

''(g) CREDITS FOR NONPROFIT ORGANIZATIONS.—Any credit which would be allowable under subsection (a) with respect to a qualified small business if such qualified small business were not exempt from tax under this chapter shall be treated as a credit allowable under this subpart to such qualified small business.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

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

''Sec. 36. Small business employee health insurance expenses.

''Sec. 37. Overpayments of tax.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2006.

**SEC. 16. EFFECTIVE DATE.**

Except as provided in section 10(e), this Act shall take effect on the date of enactment of this Act and shall apply to contracts that take effect with respect to calendar year 2007 and each calendar year thereafter.

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**SA 3900.** Mr. CARPER (for himself and Mrs. FEINSTEIN) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ____. CANCER SCREENING.**

(a) FINDINGS.—Congress makes the following findings:

(1) About 1,400,000 new cases of cancer will be diagnosed in the United States in 2006.

(2) Medical costs, lost wages, and lost productivity due to cancer cost the United States and estimated $210,000,000,000 in 2005.

(3) In 2006, cancer will take the lives of 565,000 Americans, or about 1,500 people per day.

(4) About half of all new cancer cases can be prevented or detected earlier through screening.

(5) The 5 year survival rate for cancers of the breast, colon, rectum, cervix, prostate, oral cavity, and skin is currently about 86 percent, in part due to earlier diagnosis through screening. If these cancers were diagnosed at the earliest stage through regular cancer screenings, that survival rate could increase to 95 percent.

(b) LIMITATIONS.—Notwithstanding any other provision of this Act (or an amendment made by this Act), nothing in this Act (or amendment) shall be construed to permit a small business health plan to be offered in a State, or to permit the offering of any other health insurance coverage in such State, if the plan or coverage fails to comply with laws of the State that require coverage for cancer screening, including screening for breast, cervical, colorectal, prostate, lung, uterine, skin, colon, stomach, and other cancers.

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**SA 3901.** Mr. AKAKA (for himself and Mr. OBAMA) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. REPEAL OF REQUIREMENT FOR DOCUMENTATION EVIDENCING CITIZENSHIP OR NATIONALITY AS A CONDITION FOR RECEIPT OF MEDICAL ASSISTANCE UNDER THE MEDICAID PROGRAM.**

(a) REPEAL.—Subsections (i)(22) and (x) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as added by section 6036 of the Deficit Reduction Act of 2005, are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)—

(i) in paragraph (20), by adding ''or'' after the semicolon at the end; and

(ii) in paragraph (21), by striking ''; or'' and inserting a period;

(B) by redesignating subsection (y), as added by section 6043(b) of the Deficit Reduction Act of 2005, as subsection (x); and

(C) by redesignating subsection (z), as added by section 6081(a) of the Deficit Reduction Act of 2005, as subsection (y).

(2) Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 is repealed.

(c) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005.

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**SA 3902.** Mr. PRYOR submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

Strike title III.

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**SA 3903.** Mr. REED submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the end of the amendment, add the following:

**TITLE ___—MISCELLANEOUS PROVISIONS**

**SEC. ___. GAO EVALUATION.**

(a) IN GENERAL.—Not later than 24 months after the date of enactment of this Act, the Government Accountability Office shall conduct a study, and submit to the appropriate committees of Congress a report, concerning the impact of this Act (and the amendments made by this Act) on the costs and quality of health care coverage.

(b) REPEAL.—If the study and report under subsection (a) finds that the implementation of this Act (and amendments) does not result in a decrease in health care coverage costs or in an increase in access to such coverage, the provisions of this Act (and such amendments) shall be repealed effective on the date on which such report is submitted.

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**SA 3904.** Mr. REED submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON PREEMPTION.**

Unless otherwise specifically provided for in this Act (or an amendment made by this Act), nothing in this Act (or amendment) shall be construed to preempt any State or local law related to health insurance.

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**SA 3905.** Mr. REED submitted an amendment intended to be proposed by him to the 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 the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. BENEFIT REVIEW PANEL ON HEALTH INSURANCE.**

(a) BENEFIT REVIEW PANEL.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with the National Association of Insurance Commissioners, shall establish the Benefit Review Panel on Health Insurance (referred to in this section as the ''Panel'') to develop recommendations that a Federal floor of benefit mandates be established from the current array of inconsistent State health insurance laws and in accordance with the laws adopted in a plurality of the States.

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

(A) Two State insurance commissioners, of which—

(i) 1 shall be a Democrat and 1 shall be a Republican; and

(ii) 1 shall be designated as the chairperson and 1 shall be designated as the vice-chairperson.

(B) Two representatives of State government, of which—

(i) 1 shall be a governor of a State and 1 shall be a State legislator; and

(ii) 1 shall be a Democrat and 1 shall be a Republican.

(C) Two representatives of employers, of which 1 shall represent small employers and 1 shall represent large employers.

(D) Two representatives of health insurers, of which 1 shall represent insurers that offer coverage in all markets (including individual, small, and large markets), and 1 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 Panel shall serve for the duration of the Panel. The Secretary shall fill vacancies in the Panel as needed and in a manner consistent with the composition described in paragraph (2).

(b) DEVELOPMENT OF A FEDERAL STANDARD BENEFIT PACKAGE.—In accordance with the process described in subsection (c), the Panel shall identify and recommend a Federal standard benefit package of benefit mandates from among the current array of inconsistent State insurance laws.

(c) PROCESS FOR DEVELOPING A STANDARD FEDERAL BENEFIT PACKAGE.—

(1) IN GENERAL.—In developing the standard benefit package recommendations described in subsection (b), the Panel shall—

(A) review all State laws that regulate insurance benefits; and

(B) develop recommendations to harmonize inconsistent State insurance laws with the laws adopted in a plurality of the States.

(2) CONSULTATION.—The Panel shall consult with the National Association of Insurance Commissioners in identifying the benefit mandates of the States.

(d) RECOMMENDATIONS AND ADOPTION BY SECRETARY.—

(1) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Panel shall recommend to the Secretary the adoption of the harmonized standards identified under subsection (c).

(2) REGULATIONS.—Not later than 120 days after receipt of the Panel's recommendations under paragraph (1), the Secretary shall issue final regulations adopting such recommendations as the Federal standard benefit package. If the Secretary finds the recommended standards for an element of the standard benefit package to be arbitrary and inconsistent with the plurality requirements of this section, the Secretary may issue a unique standard only for such element, through 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 Panel shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

(f) UPDATED STANDARD BENEFIT PACKAGE.—

(1) IN GENERAL.—Not later than 2 years after the termination of the Panel under subsection (e), and every 2 years thereafter, the Secretary shall update the standard benefit package adopted under subsection (d)(2). Such updated standard benefit package shall be adopted in accordance with paragraph (2).

(2) UPDATED STANDARD BENEFIT PACKAGE.—

(A) IN GENERAL.—In order to update the standard benefit package in accordance with paragraph (1), the Secretary shall review all State laws that regulate insurance mandates and identify whether a plurality of States have adopted substantially similar requirements that differ from the standard benefit package adopted by the Secretary under 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 in the standard benefit package by the Secretary. Substantially similar requirements by different States shall be considered to be an updated harmonized standard.

(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 benefit mandates of the States under this paragraph. Nothing in this subparagraph shall be construed to prohibit

the Secretary from issuing updated standards in the absence of such a report.

(C) REGULATIONS.—The Secretary shall issue regulations adopting the updated standard benefit package under this paragraph within 90 days of identifying the standards in need of updating. 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 in the standard benefit package 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 standard benefit package adopted under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of benefits that shall be included in such 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 the Federal standard benefit package under this section, the States may adopt such standard benefit package (and become an adopting State) and, in which case, shall enforce the harmonized standard benefit package pursuant to State law.

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**SA 3906.** Mr. BAUCUS submitted an amendment intended to be proposed by him to the 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 the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. STATE OPT OUT.**

(a) IN GENERAL.—The provisions of this Act (and the amendments made by this Act) shall not apply with respect to a State if—

(1) the governor of such State certifies to the State legislature that the application of such provisions would have a detrimental effect on the residents of the State; and

(2) the State enacts legislation that provides that such provisions shall not apply in the State.

(b) PARTIAL OPT OUT.—A State may apply subsection with respect to all of the provisions of this Act (or amendments) or to select provisions.

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**SA 3907.** Mr. BAUCUS submitted an amendment intended to be proposed by him to the 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 the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS**

(a) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) increasing the premiums paid by women of child bearing age for health insurance coverage;

(2) nullifying, superseding, or limiting the application of any State law that requires a health insurance issuer to provide coverage for maternity care or related per- and postnatal care for women and their infants;

(3) limiting the ability of the State to enforce any law described in paragraph (2);

shall not apply and shall not be enforced.

(b) LIMITATION ON USE OF GENDER IN SETTING RATES.—Notwithstanding any other provision of this Act (or an amendment made by this Act), a health insurance issuer that offers a small business health plan may not use gender as a characteristic in setting health insurance premium rates with respect to such plan.

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**SA 3908.** Mr. BAUCUS (for himself and Mr. COLEMAN) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. CLARIFICATION OF AVAILABILITY OF TARGETED CASE MANAGEMENT SERVICES UNDER MEDICAID.**

(a) IN GENERAL.—Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)) is amended—

(1) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by striking ''subsection'' and inserting ''title'';

(B) in subparagraph (A)—

(i) in clause (i)—

(I) by inserting ''targeted'' before ''case''; and

(II) by inserting ''that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas and'' after ''means services''; and

(ii) in clause (iii), in the matter preceding subclause (I), by striking ''Such term'' and all that follows through ''the following'' and inserting ''Except as provided in subparagraph (B), such term does not include the following activities with respect to the delivery of foster care services''; and

(C) by amending subparagraph (B) to read as follows:

''(B) Such term includes the activities described in subclauses (II) and (VIII) of subparagraph (A)(iii) in the case of an individual who is eligible for medical assistance under the State plan but who is not eligible for services or payments to be made on their behalf under part E of title IV.'';

(2) in subparagraphs (A) and (B) of paragraph (3), by inserting ''targeted'' before ''case management activity'' each place it appears;

(3) in paragraph (4), by striking ''only'' and all that follows through the period and inserting ''is available under this title for targeted case management services as furnished under the plan unless there are other third parties liable to pay for such services.''; and

(4) by adding at the end the following new paragraph:

''(6) Nothing in this subsection shall be construed as limiting the responsibility of the program established under this title to—

''(A) pay for any item or service for which no other payor is legally liable;

''(B) treat other payors or providers as legally liable who have no enforceable responsibility to pay for any item or service; or

''(C) treat the availability of public funding for any item or service as creating a legal liability.''.

(b) CONFORMING AMENDMENT.—The heading for section 6052 of the Deficit Reduction Act of 2005 (Public Law 109–171, 120 Stat. 93) is amended to read as follows: ''**clarification of availability of targeted case management services**''

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of, and the amendments to section 1915(g) of the Social Security Act made by, section 6052 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 93).

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**SA 3909.** Mr. FEINGOLD (for himself and Mr. GRAHAM) submitted an amendment intended to be proposed by him to the 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 the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**TITLE ____—HEALTH REFORM**

**SEC. ___01. SHORT TITLE.**

This title may be cited as the ''Reform Health Care Now Act''.

**SEC. ___02. SENATE CONSIDERATION OF HEALTH CARE REFORM LEGISLATION.**

(a) INTRODUCTION.—

(1) IN GENERAL.—Not later than 30 calendar days after the commencement of the session of Congress that follows the date of enactment of this Act, the chair of the Senate Committee on Health, Education, Labor, and Pensions, the Chair of the Senate Committee on Finance, the Majority Leader of the Senate, and the Minority Leader of the Senate shall each introduce a bill to provide a significant increase in access to health care coverage for the people of the United States.

(2) MINORITY PARTY.—These bills may be introduced by request and only 1 qualified bill may be introduced by each individual referred to in paragraph (1) within a Congress. If either committee chair fails to introduce the bill within the 30-day period, the ranking minority party member of the respective committee may instead introduce a bill that will qualify for the expedited procedure provided in this section.

(3) QUALIFIED BILL.—

(A) IN GENERAL.—In order to qualify as a qualified bill—

(i) the title of the bill shall be ''To reform the health care system of the United States and to provide insurance coverage for Americans.'';

(ii) the bill shall reach the goal of providing health care coverage to 95 percent of Americans within 10 years; and

(iii) the bill shall be deficit neutral.

(B) DETERMINATION.—Whether or not a bill meets the criteria in subparagraph (A) shall be determined by the Chair of the Senate Budget Committee, relying on estimates of the Congressional Budget Office, subject to the final approval of the Senate.

(b) REFERRAL.—

(1) COMMITTEE BILLS.—Upon introduction, the bill authored by the Chair of the Senate Committee on Finance shall be referred to that Committee and the bill introduced by the Chair of the Senate Committee on Health, Education, Labor, and Pensions shall be referred to that committee. If either committee has not reported the bill referred to it (or another qualified bill) by the end of a 60 calendar-day period beginning on the date of referral, the committee is, as of that date, automatically discharged from further consideration of the bill, and the bill is placed directly on the chamber's legislative calendar. In calculating the 60-day period, adjournments for more than 3 days are not counted.

(2) LEADER BILLS.—The bills introduced by the Senate Majority Leader and the Senate Minority Leader shall, on introduction, be placed directly on the Senate Calendar of Business.

(c) MOTION TO PROCEED.—

(1) IN GENERAL.—On or after the third day following the committee report or discharge or upon a bill being placed on the calendar under subsection (b)(2), it shall be in order for any Member, after consultation with the Majority Leader, to move to proceed to the consideration of any qualified bill. Notice shall first be given before proceeding. This motion to proceed to the consideration of a bill can be offered by a Member only on the day after the calendar day on which the Member announces the Member's intention to offer it.

(2) CONSIDERATION.—The motion to proceed to a given qualified bill can be made even if a motion to the same effect has previously been rejected. No more than 3 such motions may be made, however, in any 1 congressional session.

(3) PRIVILEGED AND NONDEBATABLE.—The motion to proceed is privileged, and all points of order against the motion to proceed to consideration and its consideration are waived. The motion is not debatable, is not amendable, and is not subject to a motion to postpone.

(4) NO OTHER BUSINESS OR RECONSIDERATION.—The motion is not subject to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or disagreed to is not in order.

(d) CONSIDERATION OF QUALIFIED BILL.—

(1) IN GENERAL.—If the motion to proceed is adopted, the chamber shall immediately proceed to the consideration of a qualified bill without intervening motion, order, or other business, and the bill remains the unfinished business of the Senate until disposed of. A motion to limit debate is in order and is not debatable.

(2) ONLY BUSINESS.—The qualified bill is not subject to a motion to postpone or a motion to proceed to the consideration of other business before the bill is disposed of.

(3) RELEVANT AMENDMENTS.—Only relevant amendments may be offered to the bill.

**SEC. ___03. HOUSE CONSIDERATION OF HEALTH CARE REFORM LEGISLATION.**

(a) INTRODUCTION.—

(1) IN GENERAL.—Not later than 30 calendar days after the commencement of the session of Congress that follows the date of enactment of this Act, the chair of the House Committee on Energy and Commerce, the chair of the House Committee on Ways and Means, the Majority Leader of the House, and the Minority Leader of the House shall each introduce a bill to provide a significant increase in access to health care coverage for the people of the United States.

(2) MINORITY PARTY.—These bills may be introduced by request and only 1 qualified bill may be introduced by each individual referred to in paragraph (1) within a Congress. If either committee chair fails to introduce the bill within the 30-day period, the ranking minority party member of the respective committee may, within the following 30 days, instead introduce a bill that will qualify for the expedited procedure provided in this section.

(3) QUALIFIED BILL.—

(A) IN GENERAL.—To qualify for the expedited procedure under this section as a qualified bill, the bill shall—

(i) reach the goal of providing healthcare coverage to 95 percent of Americans within 10 years; and

(ii) be deficit neutral.

(B) DETERMINATION.—Whether or not a bill meets the criteria in subparagraph (A) shall be determined by the Speaker's ruling on a point of order based on a Congressional Budget Office estimate of the bill.

(b) REFERRAL.—

(1) COMMITTEE BILLS.—Upon introduction, the bill authored by the Chair of the House Committee on Energy and Commerce shall be referred to that committee and the bill introduced by the Chair of the House Committee on Ways and Means shall be referred to that committee. If either committee has not reported the bill referred to it (or another qualified bill) by the end of 60 days of consideration beginning on the date of referral, the committee shall be automatically discharged from further consideration of the bill, and the bill shall be placed directly on the Calendar of the Whole House on the State of the Union. In calculating the 60-day period, adjournments for more than 3 days are not counted.

(2) LEADER BILLS.—The bills introduced by the House Majority Leader and House Minority Leader will, on introduction, be placed directly on the Calendar of the Whole House on the State of the Union.

(c) MOTION TO PROCEED.—

(1) IN GENERAL.—On or after the third day following the committee report or discharge or upon a bill being placed on the calendar under subsection (b)(2), it shall be in order for any Member, after consultation with the Majority Leader, to move to proceed to the consideration of any qualified bill. Notice must first be given before proceeding. This motion to proceed to the consideration of a bill can be offered by a Member only on the day after the calendar day on which the Member announces the Member's intention to offer it.

(2) CONSIDERATION.—The motion to proceed to a given qualified bill can be made even if a motion to the same effect has previously been rejected. No more than 3 such motions may be made, however, in any 1 congressional session.

(3) PRIVILEGED AND NONDEBATABLE.—The motion to proceed is privileged, and all points of order against the motion to proceed to consideration and its consideration are waived. The motion is not debatable, is not amendable, and is not subject to a motion to postpone.

(4) NO OTHER BUSINESS OR RECONSIDERATION.—The motion is not subject to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or disagreed to is not in order.

(d) CONSIDERATION OF A QUALIFIED BILL.—

(1) IN GENERAL.—If the motion to proceed is adopted, the chamber will immediately proceed to the consideration of a qualified bill without intervening motion, order, or other business, and the bill remains the unfinished business of the House until disposed of.

(2) COMMITTEE OF THE WHOLE.—The bill will be considered in the Committee of the Whole under the 5-minute rule, and the bill shall be considered as read and open for amendment at any time.

(3) LIMIT DEBATE.—A motion to further limit debate is in order and is not debatable.

(4) RELEVANT AMENDMENTS.—Only relevant amendments may be offered to the bill.

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**SA 3910.** Mr. FEINGOLD (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**TITLE ____—HEALTH CARE PURCHASING COOPERATIVES**

**SEC. ___01. SHORT TITLE.**

This title may be cited as the ''Promoting Health Care Purchasing Cooperatives Act''.

**SEC. ___02. FINDINGS AND PURPOSE.**

(a) FINDINGS.—Congress makes the following findings:

(1) Health care spending in the United States has reached 15 percent of the Gross Domestic Product of the United States, yet 45,000,000 people, or 15.6 percent of the population, remains uninsured.

(2) After nearly a decade of manageable increases in commercial insurance premiums, many employers are now faced with consecutive years of double digit premium increases.

(3) Purchasing cooperatives owned by participating businesses are a proven method of achieving the bargaining power necessary to manage the cost and quality of employer-sponsored health plans and other employee benefits.

(4) The Employer Health Care Alliance Cooperative has provided its members with health care purchasing power through provider contracting, data collection, activities to enhance quality improvements in the health care community, and activities to promote employee health care consumerism.

(5) According to the National Business Coalition on Health, there are nearly 80 employer-led coalitions across the United States that collectively purchase health care, proactively challenge high costs and the inefficient delivery of health care, and share information on quality. These coalitions represent more than 10,000 employers.

(b) PURPOSE.—It is the purpose of this title to build off of successful local employer-led health insurance initiatives by improving the value of their employees' health care.

**SEC. ___03. GRANTS TO SELF INSURED BUSINESSES TO FORM HEALTH CARE COOPERATIVES.**

(a) AUTHORIZATION.—The Secretary of Health and Human Services (in this title referred to as the ''Secretary''), acting through the Director of the Agency for Healthcare Research and Quality, is authorized to award grants to eligible groups that meet the criteria described in subsection (d), for the development of health care purchasing cooperatives. Such grants may be used to provide support for the professional staff of such cooperatives, and to obtain contracted services for planning, development, and implementation activities for establishing such health care purchasing cooperatives.

(b) ELIGIBLE GROUP DEFINED.—

(1) IN GENERAL.—In this section, the term ''eligible group'' means a consortium of 2 or more self-insured employers, including agricultural producers, each of which are responsible for their own health insurance risk pool with respect to their employees.

(2) NO TRANSFER OF RISK.—Individual employers who are members of an eligible group may not transfer insurance risk to such group.

(c) APPLICATION.—An eligible group desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and accompanied by such information as the Secretary may require.

(d) CRITERIA.—

(1) FEASIBILITY STUDY GRANTS.—

(A) IN GENERAL.—An eligible group may submit an application under subsection (c) for a grant to conduct a feasibility study concerning the establishment of a health insurance purchasing cooperative. The Secretary shall approve applications submitted under the preceding sentence if the study will consider the criteria described in paragraph (2).

(B) REPORT.—After completion of a feasibility study under a grant under this section, an eligible group shall submit to the Secretary a report describing the results of such study.

(2) GRANT CRITERIA.—The criteria described in this paragraph include the following with respect to the eligible group:

(A) The ability of the group to effectively pool the health care purchasing power of employers.

(B) The ability of the group to provide data to employers to enable such employers to make data-based decisions regarding their health plans.

(C) The ability of the group to drive quality improvement in the health care community.

(D) The ability of the group to promote health care consumerism through employee education, self-care, and comparative provider performance information.

(E) The ability of the group to meet any other criteria determined appropriate by the Secretary.

(e) COOPERATIVE GRANTS.—After the submission of a report by an eligible group under subsection (d)(1)(B), the Secretary shall determine whether to award the group a grant for the establishment of a cooperative under subsection (a). In making a determination under the preceding sentence, the Secretary shall consider the criteria described in subsection (d)(2) with respect to the group.

(f) COOPERATIVES.—

(1) IN GENERAL.—An eligible group awarded a grant under subsection (a) shall establish or expand a health insurance purchasing cooperative that shall—

(A) be a nonprofit organization;

(B) be wholly owned, and democratically governed by its member-employers;

(C) exist solely to serve the membership base;

(D) be governed by a board of directors that is democratically elected by the cooperative membership using a 1-member, 1-vote standard; and

(E) accept any new member in accordance with specific criteria, including a limitation on the number of members, determined by the Secretary.

(2) AUTHORIZED COOPERATIVE ACTIVITIES.—A cooperative established under paragraph (1) shall—

(A) assist the members of the cooperative in pooling their health care insurance purchasing power;

(B) provide data to improve the ability of the members of the cooperative to make data-based decisions regarding their health plans;

(C) conduct activities to enhance quality improvement in the health care community;

(D) work to promote health care consumerism through employee education, self-care, and comparative provider performance information; and

(E) conduct any other activities determined appropriate by the Secretary.

(g) REVIEW.—

(1) IN GENERAL.—Not later than 1 year after the date on which grants are awarded under this section, and every 2 years thereafter, the Secretary shall study programs funded by grants under this section and provide to the appropriate committees of Congress a report on the progress of such programs in improving the access of employees to quality, affordable health insurance.

(2) SLIDING SCALE FUNDING.—The Secretary shall use the information included in the report under paragraph (1) to establish a schedule for scaling back payments under this section with the goal of ensuring that programs funded with grants under this section are self sufficient within 10 years.

**SEC. ___04. GRANTS TO SMALL BUSINESSES TO FORM HEALTH CARE COOPERATIVES.**

The Secretary shall carry out a grant program that is identical to the grant program provided in section ___03, except that an eligible group for a grant under this section shall be a consortium of 2 or more employers, including agricultural producers, each of which—

(1) have 99 employees or less; and

(2) are purchasers of health insurance (are not self-insured) for their employees.

**SEC. ___05. AUTHORIZATION OF APPROPRIATIONS.**

From the administrative funds provided to the Secretary, the Secretary may use not more than a total of $60,000,000 for fiscal years 2006 through 2015 to carry out this title.

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**SA 3911.** Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. APPLICATION TO SMALL EMPLOYERS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this Act (and amendments) shall only apply to small employers (as defined in section 808(a)(10) of the Employee Retirement Income Security Act of 1974 (as added by section 101(a)) and including self-employed individuals) and health insurance coverage issued through small employers or to the employees of small employers (or self-employed individuals). Nothing in this Act (or an amendment made by this Act) shall be construed to preempt or supersede State laws relating to health insurance offered in the large group or individual markets or to limit the application of section 805(a)(3)(B) of the Employee Retirement Income Security Act of 1974 (as added by section 101(a)).

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**SA 3912.** Mr. HARKIN submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) permitting a health insurance issuer to deny coverage for a preventive service that is recommended by the United States Preventive Services Task Force through a rating of ''A'' of ''B''; or

(2) limiting the ability of a State to enforce State laws that require the coverage described in paragraph (1);

shall not apply and shall not be enforced.

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**SA 3913.** Mr. HARKIN submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) permitting a health insurance issuer to deny coverage for screening for obesity in adults and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults; or

(2) limiting the ability of a State to enforce State laws that require the coverage described in paragraph (1);

shall not apply and shall not be enforced.

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**SA 3914.** Mr. HARKIN submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROMOTING CESSATION OF TOBACCO USE BY PREGNANT WOMEN UNDER THE MEDICAID PROGRAM.**

(a) DROPPING EXCEPTION FROM MEDICAID PRESCRIPTION DRUG COVERAGE FOR TOBACCO CESSATION MEDICATIONS.—Section 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amended—

(1) by striking subparagraph (E);

(2) by redesignating subparagraphs (F) through (J) as subparagraphs (E) through (I), respectively; and

(3) in subparagraph (F) (as redesignated by paragraph (2)), by inserting before the period at the end the following: ''except, in the case of a pregnant woman, agents approved by the Food and Drug Administration for purposes of promoting, and when used to promote, tobacco cessation''.

(b) REQUIRING COVERAGE OF TOBACCO CESSATION COUNSELING SERVICES FOR PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d(a)(4)) is amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling for cessation of tobacco use (as defined in subsection (y)) for pregnant women''; and

(2) by adding at the end the following:

''(y)(1) For purposes of this title, the term 'counseling for cessation of tobacco use' means therapy and counseling for cessation of tobacco use for pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who—

''(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(2) Subject to paragraph (3), such term is limited to—

''(A) therapy and counseling services recommended in 'Treating Tobacco Use and Dependence: A Clinical Practice Guideline', published by the Public Health Service in June 2000, or any subsequent modification of such Guideline; and

''(B) such other therapy and counseling services that the Secretary recognizes to be effective.

''(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) REMOVAL OF COST SHARING FOR TOBACCO CESSATION COUNSELING SERVICES FOR PREGNANT WOMEN.—

(1) GENERAL COST SHARING PROTECTIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting '', and counseling for cessation of tobacco use (as defined in section 1905(y))'' after ''complicate the pregnancy''.

(2) ALTERNATIVE COST SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting ''or to counseling for cessation of tobacco use (as defined in section 1905(y))'' after ''''complicate the pregnancy''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to services furnished on or after that date.

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**SA 3915.** Mr. NELSON of Florida (for himself and Ms. SNOWE) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROTECTION FOR MEDICARE BENEFICIARIES WHO ENROLL IN THE PRESCRIPTION DRUG BENEFIT DURING 2006.**

(a) IN GENERAL.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–21(e)(3)(B)) is amended—

(1) in clause (iii), by striking ''May 15, 2006'' and inserting ''December 31, 2006''; and

(2) by adding at the end the following new sentence:

''An individual making an election during the period beginning on November 15, 2006, and ending on December 15, 2006, shall specify whether the election is to be effective with respect to 2006 or with respect to 2007 (or both).''.

(b) ONE-TIME CHANGE OF PLAN ENROLLMENT FOR MEDICARE PRESCRIPTION DRUG BENEFIT DURING ALL OF 2006.—

(1) IN GENERAL.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(B)—

(i) in the heading, by striking ''**for first 6 months**'';

(ii) in clause (i), by striking ''the first 6 months of 2006,'' and all that follows through ''is a Medicare+Choice eligible individual,'' and inserting ''2006,''; and

(iii) in clause (ii), by inserting ''(other than during 2006)'' after ''paragraph (3)''; and

(B) in paragraph (4), by striking ''2006'' and inserting ''2007'' each place it appears.

(2) CONFORMING AMENDMENT.—Section 1860D–1(b)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is amended by striking ''subparagraphs (B) and (C) of paragraph (2)'' and inserting ''paragraph (2)(C)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 101(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2071).

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**SA 3916.** Mr. REID (for himself, Mrs. CLINTON, Mrs. MURRAY, and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) permitting a health insurance issuer to deny, exclude, or restrict coverage for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, and outpatient contraceptive services; or

(2) limiting the ability of a State to enforce State laws that prohibit denials, exclusions, or restrictions of coverage described in paragraph (1);

shall not apply and shall not be enforced.

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**SA 3917.** Mr. BAUCUS (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. ADDITIONAL FUNDING FOR ENROLLMENT ASSISTANCE.**

(a) IN GENERAL.—There are appropriated, to be transferred from the Federal Supplementary Medical Insurance Trust Fund, not to exceed $25,000,000 for the Centers for Medicare & Medicaid Services, for the purpose of ensuring that individuals have adequate access to impartial advice on and assistance enrolling in the prescription drug program under part D of title XVIII of the Social Security Act.

(b) USE OF FUNDS.—Amounts provided under subsection (a) shall be used for the following purposes:

(1) GRANTS FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—To provide additional grants to States for State health insurance counseling programs (receiving assistance under section 4360 of the Omnibus Reconciliation Act of 1990) to broaden their capacity to—

(A) provide personal and impartial assistance to individuals seeking to enroll in a prescription drug plan or an MA–PD plan under such prescription drug program;

(B) educate and assist individuals in applying for a low-income subsidy under section 1860D–14 of such Act (42 U.S.C. 1395w–114); and

(C) assist individuals in accessing benefits under such a prescription drug plan or such an MA–PD plan once they are enrolled in a plan.

(2) GRANTS FOR INNOVATIVE PROGRAMS.—To provide grants to eligible States to support innovative programs that provide any of the services described in subparagraphs (A), (B), and (C) of paragraph (1).

(3) PROMOTION.—To widely promote and disseminate information about the existence of, and services provided by, State health insurance counseling programs.

(c) ADMINISTRATION.—

(1) SHIPS.—The amount of a grant under subsection (b)(1) from the total amount made available for such grants shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–101(a)(3))) residing in a rural area (as determined by the Administrator of the Centers for Medicare & Medicaid Services) relative to the total number of such individuals in each State, as estimated by the Administrator.

(2) INNOVATIVE PROGRAMS.—A State is eligible for a grant under subsection (b)(2) if the percentage of part D eligible individuals (as so defined) with creditable prescription drug coverage (as defined in section 1860D–13(b)(4) of the Social Security Act (42 U.S.C. 1395w–113(b)(4))) in the State is below the national average.

(d) AVAILABILITY.—Amounts provided under subsection (a) shall remain available—

(1) for obligation until December 31, 2008; and

(2) for expenditure until December 31, 2010.

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**SA 3918.** Mr. DODD (for himself and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this

Act), any provision of this Act (or amendment) that has the effect of preempting any State law that requires health plans and health insurance issuers to cover services for beneficiaries or enrollees participating in clinical trials shall not apply and shall not be enforced.

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**SA 3919.** Mr. DODD submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of preempting any State law that requires health plans and health insurance issuers to provide coverage for services for newborns and children, including pediatric and well-child care, and immunizations shall not apply and shall not be enforced.

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**SA 3920.** Mr. DODD submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of permitting health insurance issuers to vary premiums based on health status shall not apply and shall not be enforced.

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**SA 3921.** Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Internet Pharmacy Consumer Protection Act'' or the ''Ryan Haight Act''.

**SEC. 2. INTERNET SALES OF PRESCRIPTION DRUGS.**

(a) IN GENERAL.—Chapter 5 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503A the following section:

**''SEC. 503B. INTERNET SALES OF PRESCRIPTION DRUGS.**

''(a) REQUIREMENTS REGARDING INFORMATION ON INTERNET SITE.—

''(1) IN GENERAL.—A person may not dispense a prescription drug pursuant to a sale of the drug by such person if—

''(A) the purchaser of the drug submitted the purchase order for the drug, or conducted any other part of the sales transaction for the drug, through an Internet site;

''(B) the person dispenses the drug to the purchaser by mailing or shipping the drug to the purchaser; and

''(C) such site, or any other Internet site used by such person for purposes of sales of a prescription drug, fails to meet each of the requirements specified in paragraph (2), other than a site or pages on a site that—

''(i) are not intended to be accessed by purchasers or prospective purchasers; or

''(ii) provide an Internet information location tool within the meaning of section 231(e)(5) of the Communications Act of 1934 (47 U.S.C. 231(e)(5)).

''(2) REQUIREMENTS.—With respect to an Internet site, the requirements referred to in subparagraph (C) of paragraph (1) for a person to whom such paragraph applies are as follows:

''(A) Each page of the site shall include either the following information or a link to a page that provides the following information:

''(i) The name of such person.

''(ii) Each State in which the person is authorized by law to dispense prescription drugs.

''(iii) The address and telephone number of each place of business of the person with respect to sales of prescription drugs through the Internet, other than a place of business that does not mail or ship prescription drugs to purchasers.

''(iv) The name of each individual who serves as a pharmacist for prescription drugs that are mailed or shipped pursuant to the site, and each State in which the individual is authorized by law to dispense prescription drugs.

''(v) If the person provides for medical consultations through the site for purposes of providing prescriptions, the name of each individual who provides such consultations; each State in which the individual is licensed or otherwise authorized by law to provide such consultations or practice medicine; and the type or types of health professions for which the individual holds such licenses or other authorizations.

''(B) A link to which paragraph (1) applies shall be displayed in a clear and prominent place and manner, and shall include in the caption for the link the words 'licensing and contact information'.

''(b) INTERNET SALES WITHOUT APPROPRIATE MEDICAL RELATIONSHIPS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a person may not dispense a prescription drug, or sell such a drug, if—

''(A) for purposes of such dispensing or sale, the purchaser communicated with the person through the Internet;

''(B) the patient for whom the drug was dispensed or purchased did not, when such communications began, have a prescription for the drug that is valid in the United States;

''(C) pursuant to such communications, the person provided for the involvement of a practitioner, or an individual represented by the person as a practitioner, and the practitioner or such individual issued a prescription for the drug that was purchased;

''(D) the person knew, or had reason to know, that the practitioner or the individual referred to in subparagraph (C) did not, when issuing the prescription, have a qualifying medical relationship with the patient; and

''(E) the person received payment for the dispensing or sale of the drug.

For purposes of subparagraph (E), payment is received if money or other valuable consideration is received.

''(2) EXCEPTIONS.—Paragraph (1) does not apply to—

''(A) the dispensing or selling of a prescription drug pursuant to telemedicine practices sponsored by—

''(i) a hospital that has in effect a provider agreement under title XVIII of the Social Security Act (relating to the Medicare program); or

''(ii) a group practice that has not fewer than 100 physicians who have in effect provider agreements under such title; or

''(B) the dispensing or selling of a prescription drug pursuant to practices that promote the public health, as determined by the Secretary by regulation.

''(3) QUALIFYING MEDICAL RELATIONSHIP.—

''(A) IN GENERAL.—With respect to issuing a prescription for a drug for a patient, a practitioner has a qualifying medical relationship with the patient for purposes of this section if—

''(i) at least one in-person medical evaluation of the patient has been conducted by the practitioner; or

''(ii) the practitioner conducts a medical evaluation of the patient as a covering practitioner.

''(B) IN-PERSON MEDICAL EVALUATION.—A medical evaluation by a practitioner is an in-person medical evaluation for purposes of this section if the practitioner is in the physical presence of the patient as part of conducting the evaluation, without regard to whether portions of the evaluation are conducted by other health professionals.

''(C) COVERING PRACTITIONER.—With respect to a patient, a practitioner is a covering practitioner for purposes of this section if the practitioner conducts a medical evaluation of the patient at the request of a practitioner who has conducted at least one in-person medical evaluation of the patient and is temporarily unavailable to conduct the evaluation of the patient. A practitioner is a covering practitioner without regard to whether the practitioner has conducted any in-person medical evaluation of the patient involved.

''(4) RULES OF CONSTRUCTION.—

''(A) INDIVIDUALS REPRESENTED AS PRACTITIONERS.—A person who is not a practitioner (as defined in subsection (d)(1)) lacks legal capacity under this section to have a qualifying medical relationship with any patient.

''(B) STANDARD PRACTICE OF PHARMACY.—Paragraph (1) may not be construed as prohibiting any conduct that is a standard practice in the practice of pharmacy.

''(C) APPLICABILITY OF REQUIREMENTS.—Paragraph (3) may not be construed as having any applicability beyond this section, and does not affect any State law, or interpretation of State law, concerning the practice of medicine.

''(c) ACTIONS BY STATES.—

''(1) IN GENERAL.—Whenever an attorney general of any State has reason to believe that the interests of the residents of that State have been or are being threatened or adversely affected because any person has engaged or is engaging in a pattern or practice that violates section 301(l), the State may bring a civil action on behalf of its residents in an appropriate district court of the United States to enjoin such practice, to enforce compliance with such section (including a nationwide injunction), to obtain damages, restitution, or other compensation on behalf of residents of such State, to obtain reasonable attorneys fees and costs if the State prevails in the civil action, or to obtain such further and other relief as the court may deem appropriate.

''(2) NOTICE.—The State shall serve prior written notice of any civil action under paragraph (1) or (5)(B) upon the Secretary and provide the Secretary with a copy of its complaint, except that if it is not feasible for the State to provide such prior notice, the State shall serve such notice immediately upon instituting such action. Upon receiving a notice respecting a civil action, the Secretary shall have the right—

''(A) to intervene in such action;

''(B) upon so intervening, to be heard on all matters arising therein; and

''(C) to file petitions for appeal.

''(3) CONSTRUCTION.—For purposes of bringing any civil action under paragraph (1), nothing in this chapter shall prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of such State to conduct investigations or to administer oaths or affirmations or to compel the attendance of witnesses or the production of documentary and other evidence.

''(4) VENUE; SERVICE OF PROCESS.—Any civil action brought under paragraph (1) in a district court of the United States may be brought in the district in which the defendant is found, is an inhabitant, or transacts business or wherever venue is proper under section 1391 of title 28, United States Code. Process in such an action may be served in any district in which the defendant is an inhabitant or in which the defendant may be found.

''(5) ACTIONS BY OTHER STATE OFFICIALS.—

''(A) Nothing contained in this section shall prohibit an authorized State official from proceeding in State court on the basis of an alleged violation of any civil or criminal statute of such State.

''(B) In addition to actions brought by an attorney general of a State under paragraph (1), such an action may be brought by officers of such State who are authorized by the State to bring actions in such State on behalf of its residents.

''(d) GENERAL DEFINITIONS.—For purposes of this section:

''(1) The term 'practitioner' means a practitioner referred to in section 503(b)(1) with respect to issuing a written or oral prescription.

''(2) The term 'prescription drug' means a drug that is subject to section 503(b)(1).

''(3) The term 'qualifying medical relationship', with respect to a practitioner and a patient, has the meaning indicated for such term in subsection (b).

''(e) INTERNET-RELATED DEFINITIONS.—

''(1) IN GENERAL.—For purposes of this section:

''(A) The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected world-wide network of networks that employ the transmission control protocol/internet protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio.

''(B) The term 'link', with respect to the Internet, means one or more letters, words, numbers, symbols, or graphic items that appear on a page of an Internet site for the purpose of serving, when activated, as a method for executing an electronic command—

''(i) to move from viewing one portion of a page on such site to another portion of the page;

''(ii) to move from viewing one page on such site to another page on such site; or

''(iii) to move from viewing a page on one Internet site to a page on another Internet site.

''(C) The term 'page', with respect to the Internet, means a document or other file accessed at an Internet site.

''(D)(i) The terms 'site' and 'address', with respect to the Internet, mean a specific location on the Internet that is determined by Internet Protocol numbers. Such term includes the domain name, if any.

''(ii) The term 'domain name' means a method of representing an Internet address without direct reference to the Internet Protocol numbers for the address, including methods that use designations such as '.com', '.edu', '.gov', '.net', or '.org'.

''(iii) The term 'Internet Protocol numbers' includes any successor protocol for determining a specific location on the Internet.

''(2) AUTHORITY OF SECRETARY.—The Secretary may by regulation modify any definition under paragraph (1) to take into account changes in technology.

''(f) INTERACTIVE COMPUTER SERVICE; ADVERTISING.—No provider of an interactive computer service, as defined in section 230(f)(2) of the Communications Act of 1934 (47 U.S.C. 230(f)(2)), or of advertising services shall be liable under this section for dispensing or selling prescription drugs in violation of this section on account of another person's selling or dispensing such drugs, provided that the provider of the interactive computer service or of advertising services does not own or exercise corporate control over such person.''.

(b) INCLUSION AS PROHIBITED ACT.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by inserting after paragraph (k) the following:

''(l) The dispensing or selling of a prescription drug in violation of section 503B.''.

(c) INTERNET SALES OF PRESCRIPTION DRUGS; CONSIDERATION BY SECRETARY OF PRACTICES AND PROCEDURES FOR CERTIFICATION OF LEGITIMATE BUSINESSES.—In carrying out section 503B of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall take into consideration the practices and procedures of public or private entities that certify that businesses selling prescription drugs through Internet sites are legitimate businesses, including practices and procedures regarding disclosure formats and verification programs.

(d) REPORTS REGARDING INTERNET-RELATED VIOLATIONS OF STATE AND FEDERAL LAWS ON DISPENSING OF DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, pursuant to the submission of an application meeting the criteria of the Secretary, make an award of a grant or contract to the National Clearinghouse on Internet Prescribing (operated by the Federation of State Medical Boards) for the purpose of—

(A) identifying Internet sites that appear to be in violation of State or Federal laws concerning the dispensing of drugs;

(B) reporting such sites to State medical licensing boards and State pharmacy licensing boards, and to the Attorney General and the Secretary, for further investigation; and

(C) submitting, for each fiscal year for which the award under this subsection is made, a report to the Secretary describing investigations undertaken with respect to violations described in subparagraph (A).

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there is authorized to be appropriated $100,000 for each of the fiscal years 2006 through 2008.

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect upon the expiration of the 60-day period beginning on the date of the enactment of this Act, without regard to whether a final rule to implement such amendments has been promulgated by the Secretary of Health and Human Services under section 701(a) of the Federal Food, Drug, and Cosmetic Act. The preceding sentence may not be construed as affecting the authority of such Secretary to promulgate such a final rule.

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**SA 3922.** Mr. SALAZAR submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

**TITLE ____—NATIONAL COMMISSION ON HEALTH CARE ACT**

**SEC. ___1. SHORT TITLE.**

This title may be cited as the ''National Commission on Health Care Act''.

**SEC. ___2. FINDINGS.**

Congress makes the following findings:

(1) Americans spent $1.9 trillion on health care in 2005, up from $1.4 trillion in 2001.

(2) While 174 million Americans were covered by employer-sponsored health insurance in 2004, rising health care costs to both employers and employees jeopardize the ability of employers and employees to maintain needed coverage.

(3) One in every 6 people in the United States, or approximately 46 million people lacked health insurance in 2004, and the number of uninsured individuals is expected to grow.

(4) The medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) provided health insurance to 41.7 million elderly and disabled Americans in 2004, while the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) provided health care for 55 million low-income children and their parents, pregnant women, and low-income elderly individuals in 2004. Federal and State government expenditures for both programs were approximately $606 billion in 2004.

**SEC. ___3. PURPOSE.**

The purpose of this title is to establish a National Commission on Health Care to—

(1) examine and report on—

(A) the factors leading to the rising costs of health care for individuals and businesses participating in employer-based health insurance and the rising health care expenditures for public health care programs;

(B) the barriers that prevent individuals from securing adequate health care coverage; and

(C) the issues faced by people covered by public health care programs;

(2) ascertain, evaluate, and report on the evidence developed by all relevant Federal, State, and local governmental agencies regarding the facts and circumstances surrounding rising health care costs and the barriers to adequate insurance coverage;

(3) build upon the investigations of past and current entities by reviewing the findings, conclusions, and recommendations of—

(A) executive branch, congressional, or independent commission investigations into the issues of health care services or health care costs; and

(B) State and local entities that have developed innovative solutions to deal with the health care needs in their respective communities; and

(4) investigate and report to the President and the Congress on its findings, conclusions, and recommendations for policy solutions to the health care problems, including current private and public services and the lack of health care insurance for more than 45,800,0000 Americans.

**SEC. ___4. ESTABLISHMENT.**

There is established in the legislative branch the National Commission on Health Care (referred to in this title as the ''Commission'').

**SEC. ___5. COMPOSITION OF COMMISSION.**

(a) MEMBERS.—The Commission shall be composed of 10 members, of whom—

(1) 1 member shall be appointed by the President, who shall serve as the chairperson of the Commission;

(2) 1 member shall be appointed jointly by the Majority Leader of the Senate and the Speaker of the House of Representatives, after consultation with the Minority Leader of the Senate and the Minority Leader of the House of Representatives, who shall serve as vice chairperson of the Commission;

(3) 2 members shall be appointed by the senior member of the Republican leadership of the Senate;

(4) 2 members shall be appointed by the senior member of the Democratic leadership of the Senate;

(5) 2 members shall be appointed by the senior member of the Republican leadership of the House of Representatives; and

(6) 2 members shall be appointed by the senior member of the Democratic leadership of the House of Representatives.

(b) QUALIFICATIONS; INITIAL MEETING.—

(1) POLITICAL PARTY AFFILIATION.—Not more than 5 members of the Commission shall be from the same political party.

(2) NONGOVERNMENTAL APPOINTEES.—An individual appointed to the Commission may not be an officer or employee of the Federal Government or any State or local government.

(3) OTHER QUALIFICATIONS.—It is the sense of Congress that individuals appointed to the Commission should be prominent United States citizens, with national recognition and significant depth of experience in such professions or memberships as governmental service, health care services, health care administration, business, public administration, and research institutions or programs with health care emphasis.

(4) DEADLINE FOR APPOINTMENT.—All members of the Commission shall be appointed not later than May 15, 2006, or 60 days after the date of enactment of this title, whichever is later.

(5) INITIAL MEETING.—The Commission shall meet and begin the operations of the Commission as soon as practicable after all members of the Commission are appointed.

(c) QUORUM; VACANCIES.—After its initial meeting, the Commission shall meet upon the call of the chairperson or a majority of its members. Six members of the Commission shall constitute a quorum. Any vacancy in the Commission shall not affect its powers, and shall be filled in the same manner in which the original appointment was made.

**SEC. ___6. FUNCTIONS OF COMMISSION.**

(a) IN GENERAL.—The functions of the Commission are to—

(1) conduct a study that—

(A) investigates relevant facts and experiences relating to the problems within the sphere of health care, including any relevant legislation, Executive order, regulation, plan, policy, practice, or procedure; and

(B) investigates relevant facts and circumstances relating to—

(i) the rising costs of health care;

(ii) the impact of the rising costs of health care on American businesses;

(iii) the provision of health care by State and local health care agencies;

(iv) the effects of increases in insurance premiums on health care coverage for businesses and individuals;

(v) the private health insurance industry;

(vi) the public health programs;

(vii) innovations and reforms necessary to increase the provision of affordable, quality health care to all Americans;

(viii) the role of congressional oversight and resource allocation; and

(ix) other areas of the public and private sectors determined relevant by the Commission for its inquiry;

(2) identify, review, and evaluate the lessons learned from past legislative structuring of health care, coordination, management policies, and procedures of the Federal Government, and, when appropriate, State and local governments and nongovernmental entities, relative to administering, representing and implementing and receiving health care; and

(3) submit to the President and Congress such reports as are required by this title containing such findings, conclusions, and recommendations as the Commission shall determine, including proposing organization, coordination, planning, management arrangements, procedures, rules, and regulations.

**SEC. ___7. POWERS OF COMMISSION.**

(a) HEARINGS AND EVIDENCE.—The Commission or, on the authority of the Commission, any subcommittee or member thereof, may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission determines appropriate for the purposes of carrying out this title.

(b) CONTRACTING.—The Commission may, to such extent and in such amounts as are provided for in appropriation Acts, enter into contracts to enable the Commission to discharge its duties under this title.

(c) INFORMATION FROM FEDERAL AGENCIES.—

(1) IN GENERAL.—The Commission is authorized to secure directly from any executive department, bureau, agency, board, commission, office, independent establishment, or instrumentality of the Government, information, suggestions, estimates, and statistics for the purposes of this title. Each department, bureau, agency, board, commission, office, independent establishment, or instrumentality shall, to the extent authorized by law, furnish such information, suggestions, estimates, and statistics directly to the Commission, upon request made by the chairperson, the chairperson of any subcommittee created by a majority of the Commission, or any member designated by a majority of the Commission.

(2) RECEIPT, HANDLING STORAGE, AND DISSEMINATION.—Information shall only be received, handled, stored, and disseminated by members of the Commission and its staff consistent with all applicable statutes, regulations, and Executive orders.

(d) ASSISTANCE FROM FEDERAL AGENCIES.—

(1) GENERAL SERVICES ADMINISTRATION.—The Administrator of General Services shall provide to the Commission on a reimbursable basis administrative support and other services for the performance of the Commission's functions.

(2) OTHER DEPARTMENTS AND AGENCIES.—In addition to the assistance prescribed in paragraph (1), departments and agencies of the United States may provide to the Commission such services, funds, facilities, staff, and other support services as they may determine advisable and as may be authorized by law.

(e) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(f) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

**SEC. ___8. STAFF OF COMMISSION.**

(a) IN GENERAL.—

(1) APPOINTMENT AND COMPENSATION.—The chairperson of the Commission, in consultation with vice chairperson, in accordance with rules agreed upon by the Commission, may appoint and fix the compensation of a staff director and such other personnel as may be necessary to enable the Commission to carry out its functions, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this subsection may exceed the equivalent of that payable for a position at level V of the Executive Schedule under section 5316 of title 5, United States Code.

(2) PERSONNEL AS FEDERAL EMPLOYEES.—

(A) IN GENERAL.—The staff director and any personnel of the Commission who are employees shall be employees under section 2105 of title 5, United States Code, for purposes of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of that title.

(B) MEMBERS OF COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

(b) DETAILEES.—Any Federal Government employee may be detailed to the Commission without reimbursement from the Commission, and such detailee shall retain the rights, status, and privileges of the detailee's regular employment without interruption.

(c) CONSULTANT SERVICES.—The Commission is authorized to procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, but at rates not to exceed the daily rate paid a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

**SEC. ___9. COMPENSATION AND TRAVEL EXPENSES.**

(a) COMPENSATION.—Each member of the Commission may be compensated at a rate not to exceed the daily equivalent of the annual rate of basic pay in effect for a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which that member is engaged in the actual performance of the duties of the Commission.

(b) TRAVEL EXPENSES.—While away from their homes or regular places of business in the performance of services for the Commission, members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5, United States Code.

**SEC. ___10. REPORTS OF COMMISSION; TERMINATION.**

(a) INTERIM REPORTS.—The Commission may submit to the President and Congress interim reports containing such findings, conclusions, and recommendations for corrective measures as have been agreed to by a majority of Commission members.

(b) FINAL REPORT.—Not later than 12 months after the date of the enactment of this title, the Commission shall submit to the President and Congress a final report containing such findings, conclusions, and recommendations for corrective measures as have been agreed to by a majority of Commission members.

(c) TERMINATION.—

(1) IN GENERAL.—The Commission, and all the authorities of this title, shall terminate 60 days after the date on which the final report is submitted under subsection (b).

(2) ADMINISTRATIVE ACTIVITIES BEFORE TERMINATION.—The Commission may use the 60 day period referred to in paragraph (1) for the purpose of concluding its activities, including providing testimony to committees of Congress concerning its reports and disseminating the final report.

**SEC. __11. FUNDING.**

(a) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this title $6,000,000.

(b) DURATION OF AVAILABILITY.—Amounts made available to the Commission under subsection (a) shall remain available until the termination of the Commission.

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**SA 3923.** Ms. STABENOW (for herself and Mr. LEVIN) submitted an amendment intended to be proposed by her to the 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 the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**TITLE ___—THREE-SHARE PROGRAM**

**SEC. ___01. THREE-SHARE PROGRAMS.**

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

**"Subtitle C—Providing for the Uninsured**

**"SEC. 2941. THREE-SHARE PROGRAMS.**

''(a) PILOT PROGRAMS.—The Secretary, acting through the Administrator, shall award grants under this section for the startup and operation of 25 eligible three-share pilot programs for a 5-year period.

''(b) GRANTS FOR THREE-SHARE PROGRAMS.—

''(1) ESTABLISHMENT.—The Administrator may award grants to eligible entities—

''(A) to establish three-share programs;

''(B) to provide for contributions to the premiums assessed for coverage under a three-share program as provided for in subsection (c)(2)(B)(iii); and

''(C) to establish risk pools.

''(2) THREE-SHARE PROGRAM PLAN.—Each entity desiring a grant under this subsection shall develop a plan for the establishment and operation of a three-share program that meets the requirements of paragraphs (2) and (3) of subsection (c).

''(3) APPLICATION.—Each entity desiring a grant under this subsection shall submit an application to the Administrator at such time, in such manner and containing such information as the Administrator may require, including—

''(A) the three-share program plan described in paragraph (2); and

''(B) an assurance that the eligible entity will—

''(i) determine a benefit package;

''(ii) recruit businesses and employees for the three-share program;

''(iii) build and manage a network of health providers or contract with an existing network or licensed insurance provider;

''(iv) manage all administrative needs; and

''(v) establish relationships among community, business, and provider interests.

''(4) PRIORITY.—In awarding grants under this section the Administrator shall give priority to an applicant—

''(A) that is an existing three-share program;

''(B) that is an eligible three-share program that has demonstrated community support; or

''(C) that is located in a State with insurance laws and regulations that permit three-share program expansion.

''(c) GRANT ELIGIBILITY.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator, shall promulgate regulations providing for the eligibility of three-share programs for participation in the pilot program under this section.

''(2) THREE-SHARE PROGRAM REQUIREMENTS.—

''(A) IN GENERAL.—To be determined to be an eligible three-share program for purposes of participation in the pilot program under this section a three-share program shall—

''(i) be either a non-profit or local governmental entity;

''(ii) define the region in which such program will provide services;

''(iii) have the capacity to carry out administrative functions of managing health plans, including monthly billings, verification/enrollment of eligible employers and employees, maintenance of membership rosters, development of member materials (such as handbooks and identification cards), customer service, and claims processing; and

''(iv) have demonstrated community involvement.

''(B) PAYMENT.—To be eligible under paragraph (1), a three-share program shall pay the costs of services provided under subparagraph (A)(ii) by charging a monthly premium for each covered individual to be divided as follows:

''(i) Not more than 30 percent of such premium shall be paid by a qualified employee desiring coverage under the three-share program.

''(ii) Not more than 30 percent of such premium shall be paid by the qualified employer of such a qualified employee.

''(iii) At least 40 percent of such premium shall be paid from amounts provided under a grant under this section.

''(iv) Any remaining amount shall be paid by the three-share program from other public, private, or charitable sources.

''(C) PROGRAM FLEXIBILITY.—A three-share program may set an income eligibility guideline for enrollment purposes.

''(3) COVERAGE.—

''(A) IN GENERAL.—To be an eligible three-share program under this section, the three-share program shall provide at least the following benefits:

''(i) Physicians services.

''(ii) In-patient hospital services.

''(iii) Out-patient services.

''(iv) Emergency room visits.

''(v) Emergency ambulance services.

''(vi) Diagnostic lab fees and x-rays.

''(vii) Prescription drug benefits.

''(B) LIMITATION.—Nothing in subparagraph (A) shall be construed to require that a three-share program provide coverage for services performed outside the region described in paragraph (2)(A)(i).

''(C) PREEXISTING CONDITIONS.—A program described in subparagraph (A) shall not be an eligible three-share program under paragraph (1) if any individual can be excluded from coverage under such program because of a preexisting health condition.

''(d) GRANTS FOR EXISTING THREE-SHARE PROGRAMS TO MEET CERTIFICATION REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator may award grants to three-share programs that are operating on the date of enactment of this section.

''(2) APPLICATION.—Each eligible entity desiring a grant under this subsection shall submit an application to the Administrator at such time, in such manner, and containing such information as the Administrator may require.

''(e) APPLICATION OF STATE LAWS.—Nothing in this section shall be construed to preempt State law.

''(f) DISTRESSED BUSINESS FORMULA.—

''(1) IN GENERAL.—Not later than 60 days after the date of enactment of this section, the Administrator of the Health Resources and Services Administration shall develop a formula to determine which businesses qualify as distressed businesses for purposes of this section.

''(2) EFFECT ON INSURANCE MARKET.—Granting eligibility to a distressed business using the formula under paragraph (1) shall not interfere with the insurance market. Any business found to have reduced benefits to qualify as a distressed business under the formula under paragraph (1) shall not be eligible to be a three-share program for purposes of this section.

''(g) DEFINITIONS.—In this section:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(2) COVERED INDIVIDUAL.—The term 'covered individual' means—

''(A) a qualified employee; or

''(B) a child under the age of 23 or a spouse of such qualified employee who—

''(i) lacks access to health care coverage through their employment or employer;

''(ii) lacks access to health coverage through a family member;

''(iii) is not eligible for coverage under the medicare program under title XVIII or the medicaid program under title XIX; and

''(iv) does not qualify for benefits under the State Children's Health Insurance Program under title XXI.

''(3) DISTRESSED BUSINESS.—The term 'distressed business' means a business that—

''(A) in light of economic hardship and rising health care premiums may be forced to discontinue or scale back its health care coverage; and

''(B) qualifies as a distressed business according to the formula under subsection (g).

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means an entity that meets the requirements of subsection (a)(2)(A).

''(5) QUALIFIED EMPLOYEE.—The term 'qualified employee' means any individual employed by a qualified employer who meets certain criteria including—

''(A) lacking access to health coverage through a family member or common law partner;

''(B) not being eligible for coverage under the medicare program under title XVIII or the medicaid program under title XIX; and

''(C) agreeing that the share of fees described in subsection (a)(2)(B)(i) shall be paid in the form of payroll deductions from the wages of such individual.

''(6) QUALIFIED EMPLOYER.—The term 'qualified employer' means an employer as defined in section 3(d) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(d)) who—

''(A) is a small business concern as defined in section 3(a) of the Small Business Act (15 U.S.C. 632);

''(B) is located in the region described in subsection (a)(2)(A)(i); and

''(C) has not contributed to the health care benefits of its employees for at least 12 months consecutively or currently provides insurance but is classified as a distressed business.

''(h) EVALUATION.—Not later than 90 days after the end of the 5-year period during which grants are available under this section, the Government Accountability Office

shall submit to the Secretary and the appropriate committees of Congress a report concerning—

''(1) the effectiveness of the programs established under this section;

''(2) the number of individuals covered under such programs;

''(3) any resulting best practices; and

''(4) the level of community involvement.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2006 through 2011.''.

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**SA 3924.** Ms. SNOWE (for herself, Mr. BYRD, Mr. TALENT, and Mr. DOMENICI) submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

In part II of subtitle A of title XXIX of the Public Health Service Act, as added by section 201 of the amendment, strike all through section 2922 and insert the following:

**''PART II—AFFORDABLE PLANS**

**''SEC. 2921. DEFINITIONS.**

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted a law providing that small group and large group health insurers in such State may offer and sell products in accordance with the List of Required Benefits and the Terms of Application as provided for in section 2922(b)

''(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 List of Required Benefits and Terms of Application in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other applicable 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 List of Required Benefits and Terms of Application, 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 List of Required Benefits and a description of the Terms of Application, including a description of the benefits to be provided, and that adherence to such standards is included as a term of such contract.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group or large group health insurance markets, including with respect to small business health plans, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(4) LIST OF REQUIRED BENEFITS.—The term 'List of Required Benefits' means the List issued under section 2922(a).

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

''(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.

''(7) STATE PROVIDER FREEDOM OF CHOICE LAW.—The term 'State Provider Freedom of Choice Law' means a State law requiring that a health insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law.

''(8) TERMS OF APPLICATION.—The term 'Terms of Application' means terms provided under section 2922(a).

**''SEC. 2922. OFFERING AFFORDABLE PLANS.**

''(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through small business health plans, the List of Required Benefits applicable to the small group market shall apply.

''(b) TERMS OF APPLICATION.—

''(1) STATE WITH MANDATES.—With respect to a State that has a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such State mandate shall, subject to paragraph (3) (concerning uniform application), apply to a coverage plan or plan in, as applicable, the small group or large group market or through a small business health plan in such State.

''(2) STATES WITHOUT MANDATES.—With respect to a State that does not have a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such mandate shall not apply, as applicable, to a coverage plan or plan in the small group or large group market or through a small business health plan in such State.

''(3) UNIFORM APPLICATION OF LAWS.—

''(A) IN GENERAL.—With respect to a State described in paragraph (1), in applying a covered benefit, service, or category of provider mandate that is on the List of Required Benefits under subsection (a) the State shall permit a coverage plan or plan offered in the small group or large group market or through a small business health plan in such State to apply such benefit, service, or category of provider coverage in a manner consistent with the manner in which such coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code (as determined by the Secretary in consultation with the Director of the Office of Personnel Management), and consistent with the Publication of Benefit Applications under subsection (c). In the event a covered benefit, service, or category of provider appearing in the List of Required Benefits is not offered in one of the three most heavily subscribed national health plans offered under the Federal Employees Health Benefits Program, such covered benefit, service, or category of provider requirement shall be applied in a manner consistent with the manner in which such coverage is offered in the remaining most heavily subscribed plan of the remaining Federal Employees Health Benefits Program plans, as determined by the Secretary, in consultation with the Director of the Office of Personnel Management.

''(B) EXCEPTION REGARDING STATE PROVIDER FREEDOM OF CHOICE LAWS.—Notwithstanding subparagraph (A), in the event a category of provider mandate is included in the List of Covered Benefits, any State Provider Freedom of Choice Law (as defined in section 2921(7)) that is in effect in any State in which such category of provider mandate is in effect shall not be preempted, with respect to that category of provider, by this part.

''(c) PUBLICATION OF BENEFIT APPLICATIONS.—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, in consultation with the Director of the Office of Personnel Management, shall publish in the Federal Register a description of such covered benefits, services, and categories of providers covered in that calendar year by each of the three most heavily subscribed nationally available Federal Employee Health Benefits Plan options which are also included on the List of Required Benefits.

''(d) 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.

''(e) UPDATING OF LIST OF REQUIRED BENEFITS.—Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.''.

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## AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition and Forestry be authorized to conduct a full committee hearing during the session of the Senate on Wednesday, May 10, 2006 at 10 a.m. in SH–216, Hart Senate Office Building. The purpose of this hearing will be to review the implementation of the Sugar Provisions of the Farm Security and Rural Investment Act of 2002.