SA 3064. Mr. MCCONNELL (for himself, Mr. LOTT, Mr. KYL, Mr. DEMINT, Mr. COBURN, Mr. CORNYN, Mr. BUNNING, Mr. ISAKSON, and Mr. BARRASSO) submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 3065. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 3066. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 3067. Mrs. DOLE submitted an amendment intended to be proposed by her to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 3068. Mr. REID (for Mr. OBAMA (for himself, Mr. BOND, Mr. LIEBERMAN, Mrs. BOXER, and Mrs. MCCASKILL)) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 3069. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, supra; which was ordered to lie on the table.

SA 3070. Mr. SESSIONS submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, supra; which was ordered to lie on the table.

SA 3071. Mr. REID proposed an amendment to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes.

SA 3072. Mr. REID proposed an amendment to amendment SA 3071 proposed by Mr. REID to the bill H.R. 976, supra.

SA 3073. Mr. REID (for Mr. OBAMA (for himself and Mr. WHITEHOUSE)) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 3074. Mr. SPECTER (for himself and Mr. CASEY) submitted an amendment intended to be proposed by him to the joint resolution H.J. Res. 52, making continuing appropriations for the fiscal year 2008, and for other purposes; which was ordered to lie on the table.

SA 3075. Mr. BIDEN (for himself, Mr. GRAHAM, Mr. CASEY, Mr. SANDERS, Mr. BROWN, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3048. Mr. SESSIONS submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title I, add the following:

SEC. 115. M4 CARBINE RIFLE.

(a) FINDINGS.—Congress makes the following findings:

(1) The members of the Armed Forces are entitled to the best individual combat weapons available in the world today.

(2) Full and open competition in procurement is required by law, and is the most effective way of selecting the best individual combat weapons for the Armed Forces at the best price.

(3) The M4 carbine rifle is currently the individual weapon of choice for the Army, and it is procured through a sole source contract.

(4) The M4 carbine rifle has been proven in combat and meets or exceeds the existing requirements for carbines.

(5) The Army Training and Doctrine Command is conducting a full Capabilities Based Assessment (CBA) of the small arms of the Army which will determine whether or not gaps exist in the current capabilities of such small arms and inform decisions as to whether or not a new individual weapon is required to address such gaps.

(b) REPORT ON CAPABILITIES BASED ASSESSMENT.—Not later than 90 days after the date of the enactment of this Act, the Secretary of the Army shall submit to the congressional defense committees a report on the Capabilities Based Assessment of the small arms of the Army referred to in subsection (a)(5).

(c) COMPETITION FOR NEW INDIVIDUAL WEAPON.—

(1) COMPETITION REQUIRED.—In the event the Capabilities Based Assessment identifies gaps in the current capabilities of the small arms of the Army and the Secretary of the Army determines that a new individual weapon is required to address such gaps, the Secretary shall procure the new individual weapon through one or more contracts entered into after full and open competition described in paragraph (2).

(2) FULL AND OPEN COMPETITION.—The full and open competition described in this paragraph is full and open competition among all responsible manufacturers that—

(A) is open to all developmental item solutions and nondevelopmental item (NDI) solutions; and

(B) provides for the award of the contract or contracts concerned based on selection criteria that reflect the key performance parameters and attributes identified in an Army-approved service requirements document.

(d) REPORT REQUIRED.—Not later than 120 days after the date of the enactment of this Act, Secretary of Defense shall submit to the congressional defense committees a report on the feasibility and advisability of each of the following:

(1) The certification of a Joint Enhanced Carbine requirement that does not require commonality with existing technical data.

(2) The award of contracts for all available nondevelopmental carbines in lieu of a developmental program intended to meet the proposed Joint Enhanced Carbine requirement.

(3) The reprogramming of funds for the procurement of small arms from the procurement of M4 Carbines to the procurement of Joint Enhanced Carbines authorized only as the result of competition.

(4) The use of rapid equipping authority to procure weapons under $2,000 per unit that meet service-approved requirements, with such weapons being nondevelopmental items selected through full and open competition.

SA 3049. Mr. SANDERS (for himself, Mr. BYRD, Mr. BROWN, and Mr. FEINGOLD) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title III, add the following:

SEC. 325. GULF WAR ILLNESSES RESEARCH.

(a) FUNDING.—Of the amount authorized to be appropriated by section 301(5) for operation and maintenance for Defense-wide activities, $15,000,000 shall be available for the Army Medical Research and Materiel Command to carry out, as part of its Medical Research Program required by Congress, a program for Gulf War Illnesses Research.

(b) PURPOSE.—The purpose of the program shall be to develop diagnostic markers and treatments for the complex of symptoms commonly known as ''Gulf War Illnesses (GWI)'', including widespread pain, cognitive impairment, and persistent fatigue in conjunction with diverse other symptoms and abnormalities, that are associated with service in the Southwest Asia theater of operations in the early 1990s during the Persian Gulf War.

(c) PROGRAM ACTIVITIES.—

(1) Highest priority under the program shall be afforded to pilot and observational studies of treatments for the complex of symptoms described in subsection (b) and comprehensive clinical trials of such treatments that have demonstrated effectiveness in previous past pilot and observational studies.

(2) Secondary priority under the program shall be afforded to studies that identify objective markers for such complex of symptoms and biological mechanisms underlying such complex of symptoms that can lead to the identification and development of such markers and treatments.

(3) No study shall be funded under the program that is based on psychiatric illness and psychological stress as the central cause of such complex of symptoms (as is consistent with current research findings).

(d) COMPETITIVE SELECTION AND PEER REVIEW.—The program shall be conducted using competitive selection and peer review for the identification of activities having the most substantial scientific merit, utilizing individuals with recognized expertise in Gulf War illnesses in the design of the solicitation and in the scientific and programmatic review processes.

SA 3050. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the

XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of section 2111 of the Social Security Act, as added by section 112 of the House amendment to the text, add the following:

''(d) COVER KIDS FIRST IMPLEMENTATION REQUIREMENT.—Notwithstanding the preceding subsections of this section, no funds shall be available under this title for child health assistance or other health benefits coverage that is provided for any other adult other than a pregnant woman, and this title shall be applied with respect to a State without regard to such subsections, for each fiscal year quarter that begins prior to the date on which the State demonstrates to the Secretary that the State has enrolled in the State child health plan at least 95 percent of the targeted low-income children who reside in the State.''.

SA 3051. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title I of the House amendment to the text, add the following:

SEC. 117. COVER LOW-INCOME KIDS FIRST.

Section 2105(c) (42 U.S.C. 1397ee(c)), as amended section 601(a), is amended by adding at the end the following new paragraph:

''(13) NO PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE OR HEALTH BENEFITS COVERAGE FOR INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE UNLESS AT LEAST 95 PERCENT OF ELIGIBLE LOW-INCOME CHILDREN ENROLLED.—Notwithstanding any other provision of this title, for fiscal years beginning with fiscal year 2008, no payments shall be made to a State under subsection (a)(1), or any other provision of this title, for any fiscal year quarter that begins prior to the date on which the State demonstrates to the Secretary that the State has enrolled in the State child health plan at least 95 percent of the low-income children who reside in the State and are eligible for child health assistance under this State child health plan with respect to any expenditures for providing child health assistance or health benefits coverage for any individual whose gross family income exceeds 200 percent of the poverty line.''.

SA 3052. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title I of the House amendment to the text, add the following:

SEC. 117. REMOVING THE INCENTIVE TO COVER CHILDREN AT HIGHER INCOME LEVELS RATHER THAN LOWER INCOME LEVELS.

(a) ELIMINATION OF ENHANCED FMAP.—Section 2105 (42 U.S.C. 1397ee) is amended—

(1) in subsection (a)(1), in the matter preceding subparagraph (A), by striking ''enhanced FMAP (or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))'' and inserting ''Federal medical assistance percentage'';

(2) in subparagraph (A), by striking ''on the basis of an enhanced FMAP'';

(3) by striking subsection (b) and inserting the following:

''(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' has the meaning given such term in the first sentence of section 1905(b).'';

(4) in subsection (d)(B)(ii), by striking ''an enhanced FMAP'' and inserting ''payments''; and

(5) in subsection (g)(1)(B)(i), by striking ''the additional amount'' and all that follows through the period and inserting ''the Federal medical assistance percentage with respect to expenditures described in clause (ii).''.

(b) CONFORMING AMENDMENTS TO TITLE XIX.—Section 1905 (42 U.S.C. 1396d)) is amended—

(1) in subsection (b)—

(A) in the first sentence by striking ''and (4)'' and all that follows up to the period;

(B) in the last sentence—

(i) by inserting ''the Federal medical assistance percentage shall apply only'' after ''Notwithstanding the first sentence of this subsection,''; and

(ii) by striking ''section 2104'' and all that follows through the period and inserting ''section 2104.''; and

(2) in subsection (u)(4), by striking ''an enhanced FMAP described in section 2105(b)'' and inserting ''this subsection''.

(c) CONFORMING AMENDMENTS TO TITLE XXI AND THE AMENDMENTS MADE BY OTHER PROVISIONS OF THIS ACT.—

(1) Subsections (a)(2) and (b)(1) of section 2111, as added by section 106(a), are each amended by striking subparagraph (C).

(2) Section 2111(b)(2)(B), as so added, is amended—

(A) in clause (ii), by striking ''applicable percentage determined under clause (iii) or (iv) for'' and inserting ''Federal medical assistance percentage of'';

(B) by striking clauses (iii) and (iv); and

(C) by redesignating clauses (v) and (vi) as clauses (iii) and (iv), respectively.

(3) This Act shall be applied without regard to the amendment to section 2105(c) made by section 110.

(4) Section 2105(g)(4)(A), as added by section 111, is amended by striking ''the additional amount'' and all that follows through the period and inserting ''the Federal medical assistance percentage with respect to expenditures described in subparagraph (B).''.

(5) The amendment made by paragraph (1) of section 201(b) of this Act is amended to read as follows:

''(1) in the matter preceding subparagraph (A) (as amended by section 112(a)(1)(A)), by inserting '(or, in the case of expenditures described in subparagraph (D)(iv), 75 percent)' after 'Federal medical assistance percentage'; and''.

(6) Section 2105(c)(9), as added by section 301(c)(1), is amended by striking ''enhanced FMAP'' and inserting ''Federal medical assistance percentage''.

(7) Section 601(a)(2) of this Act is amended by striking '', rather than on the basis of an enhanced FMAP (as defined in section 2105(b) of such Act)''.

(8) Section 2105(c)(11), as added by section 602(a)(1), is amended by striking ''enhanced FMAP'' and inserting ''Federal medical assistance percentage''.

SA 3053. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title VI of the House amendment to the text, add the following:

SEC. 620. PERSONAL EMPOWERMENT THROUGH INDIVIDUAL RESPONSIBILITY.

Section 2103(e) (42 U.S.C. 1397cc(e)) is amended by adding at the end the following new paragraph:

''(5) PERSONAL EMPOWERMENT THROUGH INDIVIDUAL RESPONSIBILITY.—Notwithstanding the preceding provisions of this subsection or any other provision of this title, for fiscal years beginning with fiscal year 2008, a State shall not be considered to have an approved State child health plan unless the State has submitted a State plan amendment to the Secretary specifying how the State will impose premiums, deductibles, coinsurance, and other cost-sharing under the State child health plan (regardless of whether such plan is implemented under this title, title XIX, or both) for populations of individuals whose family income exceeds the effective income eligibility level applicable under the State child health plan for that population on the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, in a manner that is consistent with the authority and limitations for imposed cost-sharing under section 1916A.''.

SA 3054. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike clause (ii) of section 2105(c)(11)(B) of the Social Security Act, as added by section 301(a) of the House amendment to the text, and insert the following:

(ii) INCLUSION OF HIGH DEDUCTIBLE HEALTH PLANS; EXCLUSION OF FLEXIBLE SPENDING ARRANGEMENTS.—Such term—

(I) includes coverage consisting of a high deductible health plan (as defined in section 223(c)(2) of such Code) purchased in conjunction with a health savings account (as defined under section 223(d) of such Code); but

(II) does not include coverage consisting of benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986).

SA 3055. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VII of the House amendment to the text, add the following:

SEC. 704. DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

''SEC. 9511. DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Disease Prevention and Treatment Research Trust Fund', consisting of such amounts as may be appropriated or credited to the Disease Prevention and Treatment Research Trust Fund.

''(b) TRANSFER TO DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND OF AMOUNTS EQUIVALENT TO CERTAIN TAXES.—There are hereby appropriated to the Disease Prevention and Treatment Research Trust Fund amounts equivalent to the taxes received in the Treasury attributable to the amendments made by section 701 of the Children's Health Insurance Program Reauthorization Act of 2007.

''(c) EXPENDITURES FROM TRUST FUND.—

''(1) IN GENERAL.—Amounts in the Disease Prevention and Treatment Research Trust Fund shall be available, as provided by appropriation Acts, for the purposes of funding the disease prevention and treatment research activities of the National Institutes of Health. Amounts appropriated from the Disease Prevention and Treatment Research Trust Fund shall be in addition to any other funds provided by appropriation Acts for the National Institutes of Health.

''(2) DISEASE PREVENTION AND TREATMENT RESEARCH ACTIVITIES.—Disease prevention and treatment research activities shall include activities relating to:

''(A) CANCER.—Disease prevention and treatment research in this category shall include activities relating to pediatric, lung, breast, ovarian, uterine, prostate, colon, rectal, oral, skin, bone, kidney, liver, stomach, bladder, thyroid, pancreatic, brain and nervous system, and blood-related cancers, including leukemia and lymphoma. Priority in this category shall be given to disease prevention and treatment research into pediatric cancers.

''(B) RESPIRATORY DISEASES.—Disease prevention and treatment research in this category shall include activities relating to chronic obstructive pulmonary disease, tuberculosis, bronchitis, asthma, and emphysema.

''(C) CARDIOVASCULAR DISEASES.—Disease prevention and treatment research in this category shall include activities relating to peripheral arterial disease, heart disease, valve disease, stroke, and hypertension.

''(D) OTHER DISEASES, CONDITIONS, AND DISORDERS.—Disease prevention and treatment research in this category shall include activities relating to autism, diabetes (including type I diabetes, also known as juvenile diabetes, and type II diabetes), muscular dystrophy, Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis, cerebral palsy, cystic fibrosis, spinal muscular atrophy, osteoporosis, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), depression and other mental health disorders, infertility, arthritis, anaphylaxis, lymphedema, psoriasis, eczema, lupus, cleft lip and palate, fibromyalgia, chronic fatigue and immune dysfunction syndrome, alopecia areata, and sepsis.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9511. Disease Prevention and Treatment Research Trust Fund.''.

SA 3056. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 112 of the House amendment to the text and insert the following:

SEC. 112. ELIMINATION OF COVERAGE FOR NONPREGNANT ADULTS.

(a) ELIMINATION OF COVERAGE.—Title XXI (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following new section:

''SEC. 2111. ELIMINATION OF COVERAGE FOR NONPREGNANT ADULTS.

''(a) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS AND NONPREGNANT PARENTS.—

''(1) TERMINATION OF COVERAGE UNDER APPLICABLE EXISTING WAIVERS.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided for any other adult other than a pregnant woman after September 30, 2007.

''(2) NO NEW WAIVERS.—Notwithstanding section 1115 or any other provision of this title the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman.

''(b) INCREASED OUTREACH AND COVERAGE OF LOW-INCOME CHILDREN.—A State that, but for the application of subsections (a) and (b), would have expended funds for child health assistance or other health benefits coverage for an adult other than a pregnant woman after fiscal year 2007 shall use the funds that would have been expended for such assistance or coverage to conduct outreach to, and provide child health assistance for, low-income children who are eligible for such assistance under the State child health plan.

''(c) NONAPPLICATION.—Beginning with fiscal year 2008, this title shall be applied without regard to any provision of this title that would be contrary to the prohibition on providing child health assistance or health benefits coverage for an adult other than a pregnant woman established under this section.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(A) by striking '', the Secretary'' and inserting '':

''(1) The Secretary'';

(B) in the first sentence, by inserting ''or a nonpregnant parent (as defined in section 2111(d)(2)) of a targeted low-income child'' before the period;

(C) by striking the second sentence; and

(D) by adding at the end the following new paragraph:

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2111.''.

(2) Section 6102(c) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 131) is amended by striking ''Nothing'' and inserting ''Subject to section 2111 of the Social Security Act, as added by section 106(a)(1) of the Children's Health Insurance Program Reauthorization Act of 2007, nothing''.

SA 3057. Mr. MARTINEZ submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

In lieu of the matter proposed to be inserted to the text by the House amendment to the text, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''State Children's Health Insurance Program Reauthorization Act of 2007''.

SEC. 2. 5-YEAR SCHIP REAUTHORIZATION FOR COVERAGE OF LOW-INCOME CHILDREN.

(a) FUNDING.—

(1) INCREASE IN NATIONAL APPROPRIATION.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(A) in paragraph (9), by striking ''and'' at the end;

(B) in paragraph (10), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(11) for each of fiscal years 2008 through 2012, $7,000,000,000.''.

(2) CONTINUATION OF ADDITIONAL ALLOTMENTS TO TERRITORIES AT FISCAL YEAR 2007 LEVEL OF AUTHORITY.—Section 2104(c)(4)(B) of the Social Security Act (42 U.S.C. 1397dd(c)(4)(B)) is amended by striking ''fiscal year 2007'' and inserting ''each of fiscal years 2007 through 2012''.

(3) APPLICATION TO OTHER SCHIP FUNDING FOR FISCAL YEAR 2008.—Notwithstanding any other provision of law, if funds are appropriated under any law (other than this Act) to provide allotments to States under title XXI of the Social Security Act for all (or any portion) of fiscal year 2008—

(A) any amounts that are so appropriated that are not so allotted and obligated before the date of the enactment of this Act are rescinded; and

(B) any amount provided for such title XXI allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

(b) NO FEDERAL MATCHING PAYMENTS FOR COVERAGE OF INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) NO PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE OR HEALTH BENEFITS COVERAGE FOR INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE.—Notwithstanding any other provision of this title, for fiscal years beginning with fiscal year 2008, no payments shall be made to a State under subsection (a)(1), or any other provision of this title, for any expenditures for providing child health assistance or health benefits coverage for any individual whose gross family income exceeds 200 percent of the poverty line.''.

(c) NO FEDERAL MATCHING PAYMENTS FOR COVERAGE OF INDIVIDUALS WHO ARE ELIGIBLE FOR EMPLOYER-SPONSORED COVERAGE.—

(1) IN GENERAL.—Section 2105(c) of such Act (42 U.S.C. 1397ee(c)), as amended by subsection (c), is amended by adding at the end the following new paragraph:

''(9) REQUIREMENT REGARDING EMPLOYER-SPONSORED COVERAGE.—

''(A) IN GENERAL.—No payment may be made under this title with respect to an individual who is eligible for coverage under qualified employer-sponsored coverage, either as an individual or as part of family coverage, except with respect to expenditures for providing a premium assistance subsidy for such coverage in accordance with the requirements of this paragraph.

''(B) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(i) IN GENERAL.—In this paragraph, the term 'qualified employer sponsored coverage' means a group health plan or health insurance coverage offered through an employer that is—

''(I) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(II) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(III) cost-effective, as determined under clause (ii).

''(ii) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(I) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(II) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(iii) HIGH DEDUCTIBLE HEALTH PLANS INCLUDED.—The term 'qualified employer sponsored coverage' includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on June 28, 2007.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(2) APPLICATION TO MEDICAID.—Section 1906 of the Social Security Act (42 U.S.C. 1396e) is amended by adding at the end the following new subsection:

''(d) The provisions of section 2105(c)(9) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SEC. 3. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

''(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

''(1) IN GENERAL.—From the amounts appropriated for a fiscal year under subsection (f), subject to paragraph (2), the Secretary shall award grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

''(2) 10 PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts for the fiscal year shall be used by the Secretary for expenditures during the fiscal year to carry out a national enrollment campaign in accordance with subsection (g).

''(b) AWARD OF GRANTS.—

''(1) PRIORITY FOR AWARDING.—

''(A) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

''(i) propose to target geographic areas with high rates of—

''(I) eligible but unenrolled children, including such children who reside in rural areas; or

''(II) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

''(ii) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

''(B) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (f) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

''(2) 2-YEAR AVAILABILITY.—A grant awarded under this section for a fiscal year shall remain available for expenditure through the end of the succeeding fiscal year.

''(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

''(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

''(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

''(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

''(4) an assurance that the eligible entity shall—

''(A) conduct an assessment of the effectiveness of such activities against the performance measures;

''(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments.

''(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

''(d) SUPPLEMENT, NOT SUPPLANT.—Federal funds awarded under this section shall be used to supplement, not supplant, non-Federal funds that are otherwise available for activities funded under this section.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State with an approved child health plan under this title.

''(B) A local government.

''(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

''(D) A Federal health safety net organization.

''(E) A State, national, local, or community-based public or nonprofit private organization.

''(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

''(G) An elementary or secondary school.

''(H) A national, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

''(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

''(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

''(D) any other entity or consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

''(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(4) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health or nutrition needs; and

''(F) by providing referral and followup services.

''(f) APPROPRIATION.—

''(1) IN GENERAL.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for the purpose of awarding grants under this section $100,000,000 for each of fiscal years 2008 through 2012.

''(2) GRANTS IN ADDITION TO OTHER AMOUNTS PAID.—Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

''(g) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2) for a fiscal year, the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

''(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

''(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

''(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

''(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

''(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

''(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.''.

(b) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

''(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH AND ENROLLMENT.—The limitation under subparagraph (A) shall not apply with respect to expenditures for outreach activities under section 2102(c)(1), or for enrollment activities, for children eligible for child health assistance under the State child health plan or medical assistance under the State plan under title XIX.''.

SEC. 4. EXPANSION OF CHILD HEALTH CARE INSURANCE COVERAGE THROUGH TAX FAIRNESS.

(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 by inserting after section 35 the following new section:

''SEC. 36. CHILD HEALTH INSURANCE COSTS.

''(a) IN GENERAL.—In the case of an eligible taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to—

''(1) the amount paid by the taxpayer during the taxable year for qualified health insurance for any dependent child of such taxpayer, plus

''(2) if such amount does not exceed the limitation under subsection (b), an amount equal to such difference and paid by the Secretary into a designated account of the taxpayer for the sole benefit of such dependent child.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to an eligible taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for the individual referred to in subsection (a) for whom such taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

''(2) MONTHLY LIMITATION.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12th of $1,200.

''(3) COVERAGE MONTH.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

''(i) as of the first day of such month such individual is covered by qualified health insurance, and

''(ii) the premium for coverage under such insurance for such month is paid by an eligible taxpayer.

''(B) MEDICARE AND MEDICAID.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual—

''(i) is entitled to any benefits under title XVIII of the Social Security Act, or

''(ii) is a participant in the program under title XIX or XXI of such Act.

''(C) CERTAIN OTHER COVERAGE.—Such term shall not include any month during a taxable year with respect to an individual if, at any

time during such year, any benefit is provided to such individual under—

''(i) chapter 89 of title 5, United States Code, or

''(ii) any medical care program under the Indian Health Care Improvement Act.

''(D) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care as defined in section 213(d) without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

''(2) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

''(d) DESIGNATED ACCOUNTS.—

''(1) DESIGNATED ACCOUNT.—For purposes of this section, the term 'designated account' means any specified account established and maintained by the provider of an eligible taxpayer's qualified health insurance—

''(A) which is designated by the taxpayer (in such form and manner as the Secretary may provide) on the return of tax for the taxable year, and

''(B) which, under the terms of the account, accepts the payment described in subparagraph (A) on behalf of the taxpayer.

''(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term 'specified account' means—

''(A) any health savings account under section 223 or Archer MSA under section 220, or

''(B) any health insurance reserve account.

''(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term 'health insurance reserve account' means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.

''(4) TREATMENT OF PAYMENT.—Any payment under subsection (a)(2) to a designated account shall—

''(A) not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions),

''(B) be includible in the gross income of an eligible taxpayer for the taxable year in which the payment is made (except as provided in subparagraph (C)), and

''(C) be taken into account in determining any deduction or exclusion from gross income in the same manner as if such contribution were made by such taxpayer.

''(e) ELIGIBLE TAXPAYER; DEPENDENT; CHILD.—For purposes of this section—

''(1) ELIGIBLE TAXPAYER.—The term 'eligible taxpayer'means any taxpayer whose income exceeds 200 percent but not 300 percent of the poverty level applicable to a family of the size involved, as determined in accordance with criteria established by the Director of the Office of Management and Budget.

''(2) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152. An individual to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

''(3) CHILD.—The term 'child' means a qualifying child (as defined in section 152(c).

''(f) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by an eligible taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to such taxpayer as a credit under section 35 or as a deduction under section 213(a) or 162(l).

''(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(3) MARRIED COUPLES MUST FILE JOINT RETURN.—

''(A) IN GENERAL.—If an eligible taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

''(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

''(4) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual's coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

''(5) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

''(6) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to an eligible taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.

''(g) COORDINATION WITH ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to an eligible taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

''(h) CREDIT INCLUDED IN GROSS INCOME.—Gross income includes the amount of the credit allowed to an eligible taxpayer under this section.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050V the following new section:

''SEC. 6050W. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

''(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

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

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

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

''(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage, and

''(C) such other information as the Secretary may reasonably prescribe.

''(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 36(c)).

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

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

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xv) through (xx) as clauses (xvi) through (xxi), respectively, and by inserting after clause (xi) the following new clause:

''(xv) section 6050W (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking the period at the end of subparagraph (CC) and inserting '', or'' and by adding at the end the following new subparagraph:

''(DD) section 6050W(d) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050V the following new item:

''Sec. 6050W. Returns relating to payments for qualified health insurance.''.

(c) ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.—

(1) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

"SEC. 7529. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

''(a) GENERAL RULE.—In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

''(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

''(1) who purchases qualified health insurance (as defined in section 36(c)), and

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

''(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which—

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

''(2) estimates the amount of such credit for such taxable year, and

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

''(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the Secretary's estimate of the amount of credit allowable under section 36 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

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

(d) 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. Health insurance costs.
''Sec. 37. Overpayments of tax.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 5. LIMITATION ON EMPLOYER-PROVIDED HEALTH CARE COVERAGE.

(a) IN GENERAL.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

''(e) LIMITATION ON EMPLOYER-PROVIDED HEALTH CARE COVERAGE.—

''(1) IN GENERAL.—The amount of any exclusion under subsection (a) for any taxable year with respect to—

''(A) any employer-provided coverage under an accident or health plan which constitutes medical care, and

''(B) any employer contribution to an Archer MSA or a health savings account which is treated by subsection (b) or (d) as employer-provided coverage for medical expenses under an accident or health plan,

shall not exceed $20,000 per employee.

''(2) MEDICAL CARE DEFINED.—For purposes of paragraph (1), the term 'medical care' has the meaning given to such term in section 213(d) determined without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 6. STATE HEALTH REFORM PROJECTS.

(a) PURPOSE; ESTABLISHMENT OF STATE HEALTH CARE EXPANSION AND IMPROVEMENT PROGRAM.—The purposes of the programs approved under this section shall include, but not be limited to—

(1) achieving the goals of increased health coverage and access;

(2) ensuring that patients receive high-quality, appropriate health care;

(3) improving the efficiency of health care spending; and

(4) testing alternative reforms, such as building on the public or private health systems, or creating new systems, to achieve the objectives of this Act.

(b) APPLICATIONS BY STATES, LOCAL GOVERNMENTS, AND TRIBES.—

(1) ENTITIES THAT MAY APPLY.—

(A) IN GENERAL.—A State, in consultation with local governments, Indian tribes, and Indian organizations involved in the provision of health care, may apply for a State health care expansion and improvement program for the entire State (or for regions of the State) under paragraph (2).

(B) REGIONAL GROUPS.—A regional entity consisting of more than one State may apply for a multi-State health care expansion and improvement program for the entire region involved under paragraph (2).

(C) DEFINITION.—In this Act, the term ''State'' means the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. Such term shall include a regional entity described in subparagraph (B).

(2) SUBMISSION OF APPLICATION.—In accordance with this section, each State desiring to implement a State health care expansion and improvement program may submit an application to the State Health Innovation Commission under subsection (c) (referred to in this section as the ''Commission'') for approval.

(3) LOCAL GOVERNMENT APPLICATIONS.—

(A) IN GENERAL.—Where a State declines to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Commission for programs or projects under this subsection. Such an application shall be subject to the requirements of this section.

(B) OTHER APPLICATIONS.—Subject to such additional guidelines as the Secretary may prescribe, a unit of local government, Indian tribe, or Indian health organization may submit an application under this section, whether or not the State submits such an application, if such unit of local government can demonstrate unique demographic needs or a significant population size that warrants a substate program under this subsection.

(c) STATE HEALTH INNOVATION COMMISSION.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall establish a State Health Innovation Commission that shall—

(A) be comprised of—

(i) the Secretary;

(ii) four State governors to be appointed by the National Governors Association on a bipartisan basis;

(iii) two members of a State legislature to be appointed by the National Conference of State Legislators on a bipartisan basis;

(iv) two county officials to be appointed by the National Association of Counties on a bipartisan basis;

(v) two mayors to be appointed by the United States Conference of Mayors and the National League of Cities on a joint and bipartisan basis;

(vi) two individuals to be appointed by the Speaker of the House of Representatives;

(vii) two individuals to be appointed by the minority leader of the House of Representatives;

(viii) two individuals to be appointed by the majority leader of the Senate;

(ix) two individuals to be appointed by the minority leader of the Senate; and

(x) two individuals who are members of federally-recognized Indian tribes to be appointed on a bipartisan basis by the National Congress of American Indians;

(B) upon approval of ⅔ of the members of the Commission, provide the States with a variety of reform options for their applications, such as tax credit approaches, expansions of public programs such as medicaid and the State Children's Health Insurance Program, the creation of purchasing pooling arrangements similar to the Federal Employees Health Benefits Program, individual market purchasing options, single risk pool or single payer systems, health savings accounts, a combination of the options described in this clause, or other alternatives determined appropriate by the Commission, including options suggested by States, Indian tribes, or the public;

(C) establish, in collaboration with a qualified and independent organization such as the Institute of Medicine, minimum performance measures and goals with respect to coverage, quality, and cost of State programs, as described under subsection (d)(1);

(D) conduct a thorough review of the grant application from a State and carry on a dialogue with all State applicants concerning possible modifications and adjustments;

(E) submit the recommendations and legislative proposal described in subsection (d)(4)(B);

(F) be responsible for monitoring the status and progress achieved under program or projects granted under this section;

(G) report to the public concerning progress made by States with respect to the performance measures and goals established under this Act, the periodic progress of the State relative to its State performance measures and goals, and the State program application procedures, by region and State jurisdiction;

(H) promote information exchange between States and the Federal Government; and

(I) be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State program on national employer groups, provider organizations, and insurers because of differing State requirements under the programs.

(2) PERIOD OF APPOINTMENT; REPRESENTATION REQUIREMENTS; VACANCIES.—Members shall be appointed for a term of 5 years. In appointing such members under paragraph (1)(A), the designated appointing individuals shall ensure the representation of urban and rural areas and an appropriate geographic distribution of such members. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(3) CHAIRPERSON, MEETINGS.—

(A) CHAIRPERSON.—The Commission shall select a Chairperson from among its members.

(B) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(C) MEETINGS.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(4) POWERS OF THE COMMISSION.—

(A) NEGOTIATIONS WITH STATES.—The Commission may conduct detailed discussions and negotiations with States submitting applications under this section, either individually or in groups, to facilitate a final set of recommendations for purposes of subsection (d)(4)(B). Such negotiations shall include consultations with Indian tribes, and be conducted in a public forum.

(B) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(C) MEETINGS.—In addition to other meetings the Commission may hold, the Commission shall hold an annual meeting with the participating States under this section for the purpose of having States report progress toward the purposes in subsection (a)(1) and for an exchange of information.

(D) INFORMATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission if the head of the department or agency involved determines it appropriate.

(E) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(5) PERSONNEL MATTERS.—

(A) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government or of a State or local government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(C) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(D) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(E) TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(6) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated $3,000,000 for fiscal year 2007 and each fiscal year thereafter.

(d) REQUIREMENTS FOR PROGRAMS.—

(1) STATE PLAN.—A State that seeks to receive a grant under subsection (f) to operate a program under this section shall prepare and submit to the Commission, as part of the application under subsection (b), a State health care plan that shall have as its goal improvements in coverage, quality and costs. To achieve such goal, the State plan shall comply with the following:

(A) COVERAGE.—With respect to coverage, the State plan shall—

(i) provide and describe the manner in which the State will ensure that an increased number of individuals residing within the State will have expanded access to health care coverage with a specific 5-year target for reduction in the number of uninsured individuals through either private or public program expansion, or both, in accordance with the options established by the Commission;

(ii) describe the number and percentage of current uninsured individuals who will achieve coverage under the State health program;

(iii) describe the minimum benefits package that will be provided to all classes of beneficiaries under the State health program;

(iv) identify Federal, State, or local and private programs that currently provide health care services in the State and describe how such programs could be coordinated with the State health program, to the extent practicable; and

(v) provide for improvements in the availability of appropriate health care services that will increase access to care in urban, rural, and frontier areas of the State with medically underserved populations or where there is an inadequate supply of health care providers.

(B) QUALITY.—With respect to quality, the State plan shall—

(i) provide a plan to improve health care quality in the State, including increasing effectiveness, efficiency, timeliness, patient focused, equity while reducing health disparities, and medical errors; and

(ii) contain appropriate results-based quality indicators established by the Commission that will be addressed by the State as well as State-specific quality indicators.

(C) COSTS.—With respect to costs, the State plan shall—

(i) provide that the State will develop and implement systems to improve the efficiency of health care, including a specific 5-year target for reducing administrative costs (including paperwork burdens);

(ii) describe the public and private sector financing to be provided for the State health program;

(iii) estimate the amount of Federal, State, and local expenditures, as well as, the costs to business and individuals under the State health program;

(iv) describe how the State plan will ensure the financial solvency of the State health program; and

(v) provide that the State will prepare and submit to the Secretary and the Commission such reports as the Secretary or Commission may require to carry out program evaluations.

(D) HEALTH INFORMATION TECHNOLOGY.—With respect to health information technology, the State plan shall provide methodology for the appropriate use of health information technology to improve infrastructure, such as improving the availability of evidence-based medical and outcomes data to providers and patients, as well as other health information (such as electronic health records, electronic billing, and electronic prescribing).

(2) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing applications and plans under this section, including technical assistance by private sector entities if determined appropriate by the Commission.

(3) INITIAL REVIEW.—With respect to a State application for a grant under subsection (b), the Secretary and the Commission shall complete an initial review of such State application within 60 days of the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Commission shall advise the State within such period of the need to submit additional information.

(4) FINAL DETERMINATION.—

(A) IN GENERAL.—Not later than 90 days after completion of the initial review under paragraph (3), the Commission shall determine whether to submit a State proposal to Congress for approval.

(B) VOTING.—

(i) IN GENERAL.—The determination to submit a State proposal to Congress under subparagraph (A) shall be approved by ⅔ of the members of the Commission who are eligible to participate in such determination subject to clause (ii).

(ii) ELIGIBILITY.—A member of the Commission shall not participate in a determination under subparagraph (A) if—

(I) in the case of a member who is a Governor, such determination relates to the State of which the member is the Governor; or

(II) in the case of member not described in subclause (I), such determination relates to the geographic area of a State of which such member serves as a State or local official.

(C) SUBMISSION.—Not later than 90 days prior to October 1 of each fiscal year, the Commission shall submit to Congress a list, in the form of a legislative proposal, of the State applications that the Commission recommends for approval under this section.

(D) APPROVAL.—With respect to a fiscal year, a State proposal that has been recommended under subparagraph (B) shall be deemed to be approved, and subject to the availability of appropriations, Federal funds shall be provided to such program, unless a joint resolution has been enacted disapproving such proposal as provided for in subsection (e). Nothing in the preceding sentence shall be construed to include the approval of State proposals that involve waivers or modifications in applicable Federal law.

(5) PROGRAM OR PROJECT PERIOD.—A State program or project may be approved for a period of 5 years and may be extended for subsequent 5-year periods upon approval by the Commission and the Secretary, based upon achievement of targets, except that a shorter period may be requested by a State and granted by the Secretary.

(e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION AND COMMITTEE CONSIDERATION.—

(A) INTRODUCTION.—The legislative proposal submitted pursuant to subsection (d)(4)(B) shall be in the form of a joint resolution (in this subsection referred to as the ''resolution''). Such resolution shall be introduced in the House of Representatives by the Speaker, and in the Senate, by the majority leader, immediately upon receipt of the language and shall be referred to the appropriate committee of Congress. If the resolution is not introduced in accordance with the preceding sentence, the resolution may be introduced in either House of Congress by any member thereof.

(B) COMMITTEE CONSIDERATION.—A resolution introduced in the House of Representatives shall be referred to the Committee on Ways and Means of the House of Representatives. A resolution introduced in the Senate shall be referred to the Committee on Finance of the Senate. Not later than 15 calendar days after the introduction of the resolution, the committee of Congress to which the resolution was referred shall report the resolution or a committee amendment thereto. If the committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its introduction or at the end of the first day after there has been reported to the House involved a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such reform bill and such reform bill shall be placed on the appropriate calendar of the House involved.

(2) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—Not later than 5 days after the date on which a committee has been discharged from consideration of a resolution, the Speaker of the House of Representatives, or the Speaker's designee, or the majority leader of the Senate, or the leader's designee, shall move to proceed to the consideration of the committee amendment to the resolution, and if there is no such amendment, to the resolution. It shall also be in order for any member of the House of Representatives or the Senate, respectively, to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or 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 not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives or the Senate, as the case may be, shall immediately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives or the Senate, as the case may be, until disposed of.

(B) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the resolution that was introduced in such House, such House receives from the other House a resolution as passed by such other House—

(i) the resolution of the other House shall not be referred to a committee and may only be considered for final passage in the House that receives it under clause (iii);

(ii) the procedure in the House in receipt of the resolution of the other House, with respect to the resolution that was introduced in the House in receipt of the resolution of the other House, shall be the same as if no resolution had been received from the other House; and

(iii) notwithstanding clause (ii), the vote on final passage shall be on the reform bill of the other House.

Upon disposition of a resolution that is received by one House from the other House, it shall no longer be in order to consider the resolution bill that was introduced in the receiving House.

(C) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the resolution that results in a disagreement between the two Houses of Congress with respect to the resolution, conferees shall be appointed and a conference convened. Not later than 10 days after the date on which conferees are appointed, the conferees shall file a report with the House of Representatives and the Senate resolving the differences between the Houses on the resolution. Notwithstanding any other rule of the House of Representatives or the Senate, it shall be in order to immediately consider a report of a committee of conference on the resolution filed in accordance with this subclause. Debate in the House of Representatives and the Senate on the conference report shall be limited to 10 hours, equally divided and controlled by the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees and the majority and minority leaders of the Senate or their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report.

(3) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(4) LIMITATION.—The amount of Federal funds provided with respect to any State proposal that is deemed approved under subsection (d)(3) shall not exceed the cost provided for such proposals within the concurrent resolution on the budget as enacted by Congress for the fiscal year involved.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide a grant to a State that has an application approved under subsection (b) to enable such State to carry out an innovative State health program in the State.

(2) AMOUNT OF GRANT.—The amount of a grant provided to a State under paragraph (1) shall be determined based upon the recommendations of the Commission, subject to the amount appropriated under subsection (k).

(3) PERFORMANCE-BASED FUNDING ALLOCATION AND PRIORITIZATION.—In awarding grants under paragraph (1), the Secretary shall—

(A) fund a diversity of approaches as provided for by the Commission in subsection (c)(1)(B);

(B) give priority to those State programs that the Commission determines have the greatest opportunity to succeed in providing expanded health insurance coverage and in providing children, youth, and other vulnerable populations with improved access to health care items and services; and

(C) link allocations to the State to the meeting of the goals and performance measures relating to health care coverage, quality, and health care costs established under this Act through the State project application process.

(4) MAINTENANCE OF EFFORT.—A State, in utilizing the proceeds of a grant received under paragraph (1), shall maintain the expenditures of the State for health care coverage purposes for the support of direct health care delivery at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received.

(5) REPORT.—At the end of the 5-year period beginning on the date on which the Secretary awards the first grant under paragraph (1), the State Health Innovation Advisory Commission established under subsection (c) shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States receiving grants under paragraph (1) in meeting the goals of expanded coverage, improved quality, and cost containment through performance measures established during the 5-year period of the grant. Such report shall contain the recommendation of the Commission concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(g) MONITORING AND EVALUATION.—

(1) ANNUAL REPORTS AND PARTICIPATION BY STATES.—Each State that has received a program approval shall—

(A) submit to the Commission an annual report based on the period representing the respective State's fiscal year, detailing compliance with the requirements established by the Commission and the Secretary in the approval and in this section; and

(B) participate in the annual meeting under subsection (c)(4)(B).

(2) EVALUATIONS BY COMMISSION.—The Commission, in consultation with a qualified and independent organization such as the Institute of Medicine, shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on Ways and Means of the House of Representatives annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving approvals under this section;

(B) a description of the recommendations of the Commission and actions taken based on these recommendations;

(C) an evaluation of the effectiveness of such reforms in—

(i) expanding health care coverage for State residents;

(ii) improving the quality of health care provided in the States; and

(iii) reducing or containing health care costs in the States;

(D) recommendations regarding the advisability of increasing Federal financial assistance for State ongoing or future health program initiatives, including the amount and source of such assistance; and

(E) as required by the Commission or the Secretary under subsection (f)(5), a periodic, independent evaluation of the program.

(h) NONCOMPLIANCE.—

(1) CORRECTIVE ACTION PLANS.—If a State is not in compliance with a requirement of this section, the Secretary shall develop a corrective action plan for such State.

(2) TERMINATION.—For good cause and in consultation with the Commission, the Secretary may revoke any program granted under this section. Such decisions shall be subject to a petition for reconsideration and

appeal pursuant to regulations established by the Secretary.

(i) RELATIONSHIP TO FEDERAL PROGRAMS.—

(1) IN GENERAL.—Nothing in this Act, or in section 1115 of the Social Security Act (42 U.S.C. 1315) shall be construed as authorizing the Secretary, the Commission, a State, or any other person or entity to alter or affect in any way the provisions of title XIX of such Act (42 U.S.C. 1396 et seq.) or the regulations implementing such title.

(2) MAINTENANCE OF EFFORT.—No payment may be made under this section if the State adopts criteria for benefits, income, and resource standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of the date of enactment of this Act.

(j) MISCELLANEOUS PROVISIONS.—

(1) APPLICATION OF CERTAIN REQUIREMENTS.—

(A) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

(i) IN GENERAL.—Subject to subparagraph (B), a State shall not permit the imposition of any preexisting condition exclusion for covered benefits under a program or project under this section.

(ii) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State program or project provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the program or project may permit the imposition of a preexisting condition exclusion but only insofar and to the extent that such exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(B) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under the program or project shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(2) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in any other provision of law, no payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) of the Social Security Act shall apply.

(3) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of the Social Security Act shall apply to States under this section in the same manner as they apply to a State under such title XIX:

(A) TITLE XIX PROVISIONS.—

(i) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(ii) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(iii) Section 1903(w) (relating to limitations on provider taxes and donations).

(iv) Section 1920A (relating to presumptive eligibility for children).

(B) TITLE XI PROVISIONS.—

(i) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(ii) Section 1124 (relating to disclosure of ownership and related information).

(iii) Section 1126 (relating to disclosure of information about certain convicted individuals).

(iv) Section 1128A (relating to civil monetary penalties).

(v) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(vi) Section 1132 (relating to periods within which claims must be filed).

(4) RELATION TO OTHER LAWS.—

(A) HIPAA.—Health benefits coverage provided under a State program or project under this section shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(B) ERISA.—Nothing in this section shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1))).

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary in each fiscal year. Amounts appropriated for a fiscal year under this subsection and not expended may be used in subsequent fiscal years to carry out this section.

SA 3058. Mr. KENNEDY (for himself, Mrs. MCCASKILL, Mr. LIEBERMAN, Ms. MIKULSKI, Mr. AKAKA, Mr. BROWN, and Mr. DODD) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title III, add the following:

SEC. 358. MODIFICATION TO PUBLIC-PRIVATE COMPETITION REQUIREMENTS BEFORE CONVERSION TO CONTRACTOR PERFORMANCE.

(a) COMPARISON OF RETIREMENT SYSTEM COSTS.—Section 2461(a)(1) of title 10, United States Code, is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) by redesignating subparagraph (G) as subparagraph (H); and

(3) by inserting after subparagraph (F) the following new subparagraph (G):

''(G) requires that the contractor shall not receive an advantage for a proposal that would reduce costs for the Department of Defense by—

''(i) not making an employer-sponsored health insurance plan (or payment that could be used in lieu of such a plan), health savings account, or medical savings account, available to the workers who are to be employed to perform the function under the contract;

''(ii) offering to such workers an employer-sponsored health benefits plan that requires the employer to contribute less towards the premium or subscription share than the amount that is paid by the Department of Defense for health benefits for civilian employees of the Department under chapter 89 of title 5; or

''(iii) offering to such workers a retirement benefit that, in any year, costs less than the annual retirement cost factor applicable to civilian employees of the Department of Defense under chapter 84 of title 5; and''.

(b) CONFORMING AMENDMENTS.—Such title is further amended—

(1) by striking section 2467; and

(2) in section 2461—

(A) by redesignating subsections (b) through (d) as subsections (c) through (e); and

(B) by inserting after subsection (a) the following new subsection (b):

''(b) REQUIREMENT TO CONSULT DOD EMPLOYEES.—(1) Each officer or employee of the Department of Defense responsible for determining under Office of Management and Budget Circular A–76 whether to convert to contractor performance any function of the Department of Defense—

''(A) shall, at least monthly during the development and preparation of the performance work statement and the management efficiency study used in making that determination, consult with civilian employees who will be affected by that determination and consider the views of such employees on the development and preparation of that statement and that study; and

''(B) may consult with such employees on other matters relating to that determination.

''(2)(A) In the case of employees represented by a labor organization accorded exclusive recognition under section 7111 of title 5, consultation with representatives of that labor organization shall satisfy the consultation requirement in paragraph (1).

''(B) In the case of employees other than employees referred to in subparagraph (A), consultation with appropriate representatives of those employees shall satisfy the consultation requirement in paragraph (1).

''(C) The Secretary of Defense shall prescribe regulations to carry out this subsection. The regulations shall include provisions for the selection or designation of appropriate representatives of employees referred to in subparagraph (B) for purposes of consultation required by paragraph (1).''.

(c) TECHNICAL AMENDMENTS.—Section 2461 of such title, as amended by subsection (a), is further amended—

(1) in subsection (a)(1)—

(A) in subparagraph (B), by inserting after ''2003'' the following: '', or any successor circular''; and

(B) in subparagraph (D), by striking ''and reliability'' and inserting '', reliability, and timeliness''; and

(2) in subsection (c)(2), as redesignated under subsection (b)(2), by inserting ''of'' after ''examination''.

SEC. 359. BID PROTESTS BY FEDERAL EMPLOYEES IN ACTIONS UNDER OFFICE OF MANAGEMENT BUDGET CIRCULAR A–76.

(a) ELIGIBILITY TO PROTEST PUBLIC-PRIVATE COMPETITIONS.—Section 3551(2) of title 31, United States Code, is amended to read as follows:

''(2) The term 'interested party'—

''(A) with respect to a contract or a solicitation or other request for offers described in paragraph (1), means an actual or prospective bidder or offeror whose direct economic interest would be affected by the award of the contract or by failure to award the contract; and

''(B) with respect to a public-private competition conducted under Office of Management and Budget Circular A–76 with respect to the performance of an activity or function of a Federal agency, or a decision to convert a function performed by Federal employees to private sector performance without a competition under Office of Management and Budget Circular A–76, includes—

''(i) any official who submitted the agency tender in such competition; and

''(ii) any one individual who, for the purpose of representing the Federal employees engaged in the performance of the activity or function for which the public-private competition is conducted in a protest under this subchapter that relates to such public-private competition, has been designated as the agent of the Federal employees by a majority of such employees.''.

(b) EXPEDITED ACTION.—

(1) IN GENERAL.—Subchapter V of chapter 35 of such title is amended by adding at the end the following new section:

''SEC. 3557. EXPEDITED ACTION IN PROTESTS OF PUBLIC-PRIVATE COMPETITIONS.

''For any protest of a public-private competition conducted under Office of Management and Budget Circular A–76 with respect to the performance of an activity or function of a Federal agency, the Comptroller General shall administer the provisions of this subchapter in the manner best suited for expediting the final resolution of the protest and the final action in the public-private competition.''.

(2) CLERICAL AMENDMENT.—The chapter analysis at the beginning of such chapter is amended by inserting after the item relating to section 3556 the following new item:

''3557. Expedited action in protests of public-private competitions.''.

(c) RIGHT TO INTERVENE IN CIVIL ACTION.—Section 1491(b) of title 28, United States Code, is amended by adding at the end the following new paragraph:

''(5) If an interested party who is a member of the private sector commences an action described in paragraph (1) with respect to a public-private competition conducted under Office of Management and Budget Circular A–76 regarding the performance of an activity or function of a Federal agency, or a decision to convert a function performed by Federal employees to private sector performance without a competition under Office of Management and Budget Circular A–76, then an interested party described in section 3551(2)(B) of title 31 shall be entitled to intervene in that action.''.

(d) APPLICABILITY.—Subparagraph (B) of section 3551(2) of title 31, United States Code (as added by subsection (a)), and paragraph (5) of section 1491(b) of title 28, United States Code (as added by subsection (c)), shall apply to—

(1) a protest or civil action that challenges final selection of the source of performance of an activity or function of a Federal agency that is made pursuant to a study initiated under Office of Management and Budget Circular A–76 on or after January 1, 2004; and

(2) any other protest or civil action that relates to a public-private competition initiated under Office of Management and Budget Circular A–76, or to a decision to convert a function performed by Federal employees to private sector performance without a competition under Office of Management and Budget Circular A–76, on or after the date of the enactment of this Act.

SEC. 360. PUBLIC-PRIVATE COMPETITION REQUIRED BEFORE CONVERSION TO CONTRACTOR PERFORMANCE.

(a) IN GENERAL.—The Office of Federal Procurement Policy Act (41 U.S.C. 403 et seq.) is amended by adding at the end the following new section:

''SEC. 43. PUBLIC-PRIVATE COMPETITION REQUIRED BEFORE CONVERSION TO CONTRACTOR PERFORMANCE.

''(a) PUBLIC-PRIVATE COMPETITION.—(1) A function of an executive agency performed by 10 or more agency civilian employees may not be converted, in whole or in part, to performance by a contractor unless the conversion is based on the results of a public-private competition that—

''(A) formally compares the cost of performance of the function by agency civilian employees with the cost of performance by a contractor;

''(B) creates an agency tender, including a most efficient organization plan, in accordance with Office of Management and Budget Circular A–76, as implemented on May 29, 2003, or any successor circular;

''(C) includes the issuance of a solicitation;

''(D) determines whether the submitted offers meet the needs of the executive agency with respect to factors other than cost, including quality, reliability, and timeliness;

''(E) examines the cost of performance of the function by agency civilian employees and the cost of performance of the function by one or more contractors to demonstrate whether converting to performance by a contractor will result in savings to the Government over the life of the contract, including—

''(i) the estimated cost to the Government (based on offers received) for performance of the function by a contractor;

''(ii) the estimated cost to the Government for performance of the function by agency civilian employees; and

''(iii) an estimate of all other costs and expenditures that the Government would incur because of the award of such a contract;

''(F) requires continued performance of the function by agency civilian employees unless the difference in the cost of performance of the function by a contractor compared to the cost of performance of the function by agency civilian employees would, over all performance periods required by the solicitation, be equal to or exceed the lesser of—

''(i) 10 percent of the personnel-related costs for performance of that function in the agency tender; or

''(ii) $10,000,000; and

''(G) examines the effect of performance of the function by a contractor on the agency mission associated with the performance of the function.

''(2) A function that is performed by the executive agency and is reengineered, reorganized, modernized, upgraded, expanded, or changed to become more efficient, but still essentially provides the same service, shall not be considered a new requirement.

''(3) In no case may a function being performed by executive agency personnel be—

''(A) modified, reorganized, divided, or in any way changed for the purpose of exempting the conversion of the function from the requirements of this section; or

''(B) converted to performance by a contractor to circumvent a civilian personnel ceiling.

''(b) REQUIREMENT TO CONSULT EMPLOYEES.—(1) Each civilian employee of an executive agency responsible for determining under Office of Management and Budget Circular A–76 whether to convert to contractor performance any function of the executive agency—

''(A) shall, at least monthly during the development and preparation of the performance work statement and the management efficiency study used in making that determination, consult with civilian employees who will be affected by that determination and consider the views of such employees on the development and preparation of that statement and that study; and

''(B) may consult with such employees on other matters relating to that determination.

''(2)(A) In the case of employees represented by a labor organization accorded exclusive recognition under section 7111 of title 5, consultation with representatives of that labor organization shall satisfy the consultation requirement in paragraph (1).

''(B) In the case of employees other than employees referred to in subparagraph (A), consultation with appropriate representatives of those employees shall satisfy the consultation requirement in paragraph (1).

''(C) The head of each executive agency shall prescribe regulations to carry out this subsection. The regulations shall include provisions for the selection or designation of appropriate representatives of employees referred to in paragraph (2)(B) for purposes of consultation required by paragraph (1).

''(c) CONGRESSIONAL NOTIFICATION.—(1) Before commencing a public-private competition under subsection (a), the head of an executive agency shall submit to Congress a report containing the following:

''(A) The function for which such public-private competition is to be conducted.

''(B) The location at which the function is performed by agency civilian employees.

''(C) The number of agency civilian employee positions potentially affected.

''(D) The anticipated length and cost of the public-private competition, and a specific identification of the budgetary line item from which funds will be used to cover the cost of the public-private competition.

''(E) A certification that a proposed performance of the function by a contractor is not a result of a decision by an official of an executive agency to impose predetermined constraints or limitations on such employees in terms of man years, end strengths, full-time equivalent positions, or maximum number of employees.

''(2) The report required under paragraph (1) shall include an examination of the potential economic effect of performance of the function by a contractor on—

''(A) agency civilian employees who would be affected by such a conversion in performance; and

''(B) the local community and the Government, if more than 50 agency civilian employees perform the function.

''(3)(A) A representative individual or entity at a facility where a public-private competition is conducted may submit to the head of the executive agency an objection to the public private competition on the grounds that the report required by paragraph (1) has not been submitted or that the certification required by paragraph (1)(E) is not included in the report submitted as a condition for the public private competition. The objection shall be in writing and shall be submitted within 90 days after the following date:

''(i) In the case of a failure to submit the report when required, the date on which the representative individual or an official of the representative entity authorized to pose the objection first knew or should have known of that failure.

''(ii) In the case of a failure to include the certification in a submitted report, the date on which the report was submitted to Congress.

''(B) If the head of the executive agency determines that the report required by paragraph (1) was not submitted or that the required certification was not included in the

submitted report, the function for which the public-private competition was conducted for which the objection was submitted may not be the subject of a solicitation of offers for, or award of, a contract until, respectively, the report is submitted or a report containing the certification in full compliance with the certification requirement is submitted.

''(d) EXEMPTION FOR THE PURCHASE OF PRODUCTS AND SERVICES OF THE BLIND AND OTHER SEVERELY HANDICAPPED PERSONS.—This section shall not apply to a commercial or industrial type function of an executive agency that—

''(1) is included on the procurement list established pursuant to section 2 of the Javits-Wagner-O'Day Act (41 U.S.C. 47); or

''(2) is planned to be changed to performance by a qualified nonprofit agency for the blind or by a qualified nonprofit agency for other severely handicapped persons in accordance with that Act.

''(e) INAPPLICABILITY DURING WAR OR EMERGENCY.—The provisions of this section shall not apply during war or during a period of national emergency declared by the President or Congress.''.

(b) CLERICAL AMENDMENT.—The table of sections in section 1(b) of such Act is amended by adding at the end the following new item:

''Sec. 43. Public-private competition required before conversion to contractor performance.''.

SEC. 361. PERFORMANCE OF CERTAIN WORK BY FEDERAL GOVERNMENT EMPLOYEES.

(a) GUIDELINES.—

(1) IN GENERAL.—The Under Secretary of Defense for Personnel and Readiness shall prescribe guidelines and procedures for ensuring that consideration is given to using Federal Government employees on a regular basis for new work and work that is performed under Department of Defense contracts and could be performed by Federal Government employees.

(2) CRITERIA.—The guidelines and procedures prescribed under paragraph (1) shall provide for special consideration to be given to contracts that—

(A) have been performed by Federal Government employees at any time on or after October 1, 1980;

(B) are associated with the performance of inherently governmental functions;

(C) have been performed by a contractor pursuant to a contract that was awarded on a noncompetitive basis, either a contract for a function once performed by Federal employees that was awarded without the conduct of a public-private competition or a contract that was last awarded without the conduct of an actual competition between contractors; or

(D) have been performed poorly by a contractor because of excessive costs or inferior quality, as determined by a contracting officer within the last five years .

(3) DEADLINE FOR ISSUANCE OF GUIDELINES.—The Secretary of Defense shall implement the guidelines required under paragraph (1) by not later than 60 days after the date of the enactment of this Act.

(4) ESTABLISHMENT OF CONTRACTOR INVENTORY.—The Secretary of Defense shall establish an inventory of Department of Defense contracts to determine which contracts meet the criteria set forth in paragraph (2).

(b) NEW REQUIREMENTS.—

(1) LIMITATION ON REQUIRING PUBLIC-PRIVATE COMPETITION.—No public-private competition may be required for any Department of Defense function before—

(A) the commencement of the performance by civilian employees of the Department of Defense of a new Department of Defense function;

(B) the commencement of the performance by civilian employees of the Department of Defense of any Department of Defense function described in subparagraphs (B) through (D) of subsection (a)(2); or

(C) the expansion of the scope of any Department of Defense function performed by civilian employees of the Department of Defense.

(2) CONSIDERATION OF FEDERAL GOVERNMENT EMPLOYEES.—The Secretary of Defense shall, to the maximum extent practicable, ensure that Federal Government employees are fairly considered for the performance of new requirements, with special consideration given to new requirements that include functions that—

(A) are similar to functions that have been performed by Federal Government employees at any time on or after October 1, 1980; or

(B) are associated with the performance of inherently governmental functions.

(c) USE OF FLEXIBLE HIRING AUTHORITY.—The Secretary may use the flexible hiring authority available to the Secretary under the National Security Personnel System, as established pursuant to section 9902 of title 5, United States Code, to facilitate the performance by civilian employees of the Department of Defense of functions described in subsection (b).

(d) INSPECTOR GENERAL REPORT.—Not later than 180 days after the enactment of this Act, the Inspector General of the Department of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the compliance of the Secretary of Defense with the requirements of this section.

(e) DEFINITIONS.—In this section:

(1) The term ''National Security Personnel System'' means the human resources management system established under the authority of section 9902 of title 5, United States Code.

(2) The term ''inherently governmental function'' has the meaning given that term in section 5 of the Federal Activities Inventory Reform Act of 1998 (Public Law 105–270; 112 Stat. 2384; 31 U.S.C. 501 note).

(f) CONFORMING REPEAL.—The National Defense Authorization Act for Fiscal Year 2006 (Public Law 109–163) is amended by striking section 343.

SEC. 362. RESTRICTION ON OFFICE OF MANAGEMENT AND BUDGET INFLUENCE OVER DEPARTMENT OF DEFENSE PUBLIC-PRIVATE COMPETITIONS.

(a) RESTRICTION ON OFFICE OF MANAGEMENT AND BUDGET.—The Office of Management and Budget may not direct or require the Secretary of Defense or the Secretary of a military department to prepare for, undertake, continue, or complete a public-private competition or direct conversion of a Department of Defense function to performance by a contractor under Office of Management and Budget Circular A–76, or any other successor regulation, directive, or policy.

(b) RESTRICTION ON SECRETARY OF DEFENSE.—The Secretary of Defense or the Secretary of a military department may not prepare for, undertake, continue, or complete a public-private competition or direct conversion of a Department of Defense function to performance by a contractor under Office of Management and Budget Circular A–76, or any other successor regulation, directive, or policy by reason of any direction or requirement provided by the Office of Management and Budget.

SEC. 363. PUBLIC-PRIVATE COMPETITION AT END OF PERIOD SPECIFIED IN PERFORMANCE AGREEMENT NOT REQUIRED.

Section 2461(a) of title 10, United States Code, is amended by adding at the end the following new paragraph:

''(4) A military department or defense agency may not be required to conduct a public-private competition under Office of Management and Budget Circular A–76 or any other provision of law at the end of the period specified in the performance agreement entered into in accordance with this section for any function of the Department of Defense performed by Department of Defense civilian employees.''.

SA 3059. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. TREATMENT OF UNBORN CHILDREN.

(a) CODIFICATION OF CURRENT REGULATIONS.—Section 2110(c)(1) (42 U.S.C. 1397jj(c)(1)) is amended by striking the period at the end and inserting the following: '', and includes, at the option of a State, an unborn child. For purposes of the previous sentence, the term 'unborn child' means a member of the species Homo sapiens, at any stage of development, who is carried in the womb.''.

(b) CLARIFICATIONS REGARDING COVERAGE OF MOTHERS.—Section 2103 (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

''(g) CLARIFICATIONS REGARDING AUTHORITY TO PROVIDE POSTPARTUM SERVICES AND MATERNAL HEALTH CARE.—Any State that provides child health assistance to an unborn child under the option described in section 2110(c)(1) may continue to provide such assistance to the mother, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends, in the same manner as such assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.''.

SA 3060. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

SEC. ___. STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.

(a) ELIGIBILITY BASED ON GROSS INCOME.—

(1) IN GENERAL.—Section 2110 (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.—A State shall determine family income for purposes of determining income eligibility for child health assistance or other health benefits coverage under the State child health plan (or under a waiver of such plan under section 1115) solely on the basis of the gross income (as defined by the Secretary) of the family.''.

(2) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 106(a)(2)(A), is amended by adding at the end the following new paragraph:

''(3) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the

date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2110(d) (relating to determining income eligibility on the basis of gross income) and regulations promulgated to carry out such requirements.''.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary shall promulgate interim final regulations defining gross income for purposes of section 2110(d) of the Social Security Act, as added by subsection (a)(1).

(c) APPLICATION TO CURRENT ENROLLEES.—The interim final regulations promulgated under subsection (b) shall not be used to determine the income eligibility of any individual enrolled in a State child health plan under title XXI of the Social Security Act on the date of enactment of this Act before the date on which such eligibility of the individual is required to be redetermined under the plan as in effect on such date. In the case of any individual enrolled in such plan on such date who, solely as a result of the application of subsection (d) of section 2110 of the Social Security Act (as added by subsection (a)(1))) and the regulations promulgated under subsection (b), is determined to be ineligible for child health assistance under the State child health plan, a State may elect, subject to substitution of the Federal medical assistance percentage for the enhanced FMAP under section 2105(a)(1) of the Social Security Act, to continue to provide the individual with such assistance for so long as the individual otherwise would be eligible for such assistance and the individual's family income, if determined under the income and resource standards and methodologies applicable under the State child health plan on September 30, 2007, would not exceed the income eligibility level applicable to the individual under the State child health plan.

SA 3061. Mr. CRAPO submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 613 of the proposed House amendment to the text of the Act.

SA 3062. Mr. VITTER submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

''SEC.____. Exclusion from Program.

1. No person who is not a United States citizen is eligible to receive benefits in this title.

SA 3063. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 301 of the House amendment to the text and insert the following:

SEC. 301. PREMIUM ASSISTANCE FOR HIGHER INCOME CHILDREN AND PREGNANT WOMEN WITH ACCESS TO EMPLOYER-SPONSORED COVERAGE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 211(c) is amended by adding at the end the following:

''(11) PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Beginning with fiscal year 2008, a State may only provide child health assistance for a targeted low-income child or a pregnant woman whose family income exceeds 200 percent of the poverty line and who has access to qualified employer sponsored coverage (as defined in subparagraph (B)) through the provision of a premium assistance subsidy in accordance with the requirements of this paragraph.

''(B) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(i) IN GENERAL.—In this paragraph, the term 'qualified employer sponsored coverage' means a group health plan or health insurance coverage offered through an employer that is—

''(I) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(II) for which the employer contribution toward any premium for such coverage is at least 50 percent (75 percent, in the case of an employer with more than 50 employees);

''(III) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(IV) cost-effective, as determined under clause (ii).

''(ii) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(I) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(II) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(iii) HIGH DEDUCTIBLE HEALTH PLANS INCLUDED.—The term 'qualified employer sponsored coverage' includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this

paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on June 28, 2007, for targeted low-income children or pregnant women whose family income does not exceed 200 percent of the poverty line.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage and the requirement to provide such subsidies to the individuals described in subparagraph (A);

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy, or if required, to obtain such subsidies; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(b) APPLICATION TO MEDICAID.—Section 1906 (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(11) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SA 3064. Mr. MCCONNELL (for himself, Mr. LOTT, Mr. KYL, Mr. DEMINT, Mr. COBURN, Mr. CORNYN, Mr. BUNNING, Mr. ISAKSON, and Mr. BARRASSO) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

On page 1, line 3, strike all after ''Section'' and insert the following:

1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Kids First Act''.

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

TITLE I—STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION

SEC. 101. 5-YEAR REAUTHORIZATION.

(a) INCREASE IN NATIONAL ALLOTMENT.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (9), by striking ''and'' at the end;

(2) in paragraph (10), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(11) for fiscal year 2008, $7,000,000,000;

''(12) for fiscal year 2009, $7,200,000,000;

''(13) for fiscal year 2010, $7,600,000,000;

''(14) for fiscal year 2011, $8,300,000,000; and

''(15) for fiscal year 2012, $8,800,000,000.''.

(b) CONTINUATION OF ADDITIONAL ALLOTMENTS TO TERRITORIES.—Section 2104(c)(4)(B) of the Social Security Act (42 U.S.C. 1397dd(c)(4)(B)) is amended—

(1) by striking ''and'' after ''2006,''; and

(2) by inserting before the period the following: '', $56,000,000 for fiscal year 2008, $58,000,000 for fiscal year 2009, $61,000,000 for fiscal year 2010, $66,000,000 for fiscal year 2011, and $70,000,000 for fiscal year 2012''.

SEC. 102. ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA BASED ON EXPENDITURES AND NUMBERS OF LOW-INCOME CHILDREN.

(a) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

''(i) DETERMINATION OF ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEARS 2008 THROUGH 2012.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this subsection and subject to paragraph (3), the Secretary shall allot to each subsection (b) State for each of fiscal years 2008 through 2012,, the amount determined for the fiscal year that is equal to the product of—

''(A) the amount available for allotment under subsection (a) for the fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year; and

''(B) the sum of the State allotment factors determined under paragraph (2) with respect to the State and weighted in accordance with subparagraph (B) of that paragraph for the fiscal year.

''(2) STATE ALLOTMENT FACTORS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the State allotment factors are the following:

''(i) The ratio of the projected expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the fiscal year to the sum of such projected expenditures for all States for the fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(ii) The ratio of the number of low-income children who have not attained age 19 with no health insurance coverage in the State, as determined by the Secretary on the basis of the arithmetic average of the number of such children for the 3 most recent Annual Social and Economic Supplements to the Current Population Survey of the Bureau of the Census available before the beginning of the calendar year before such fiscal year begins, to the sum of the number of such children determined for all States for such fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iii) The ratio of the projected expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the preceding fiscal year to the sum of such projected expenditures for all States for such

preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iv) The ratio of the actual expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the second preceding fiscal year to the sum of such actual expenditures for all States for such second preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(B) ASSIGNMENT OF WEIGHTS.—For each of fiscal years 2008 through 2012, the following percentage weights shall be applied to the ratios determined under subparagraph (A) for each such fiscal year:

''(i) 40 percent for the ratio determined under subparagraph (A)(i).

''(ii) 5 percent for the ratio determined under subparagraph (A)(ii).

''(iii) 50 percent for the ratio determined under subparagraph (A)(iii).

''(iv) 5 percent for the ratio determined under subparagraph (A)(iv).

''(C) DETERMINATION OF PROJECTED AND ACTUAL EXPENDITURES.—For purposes of subparagraph (A):

''(i) PROJECTED EXPENDITURES.—The projected expenditures described in clauses (i) and (iii) of such subparagraph with respect to a fiscal year shall be determined on the basis of amounts reported by States to the Secretary on the May 15th submission of Form CMS–37 and Form CMS–21B submitted not later than June 30th of the fiscal year preceding such year.

''(ii) ACTUAL EXPENDITURES.—The actual expenditures described in clause (iv) of such subparagraph with respect to a second preceding fiscal year shall be determined on the basis of amounts reported by States to the Secretary on Form CMS–64 and Form CMS–21 submitted not later than November 30 of the preceding fiscal year.''.

(b) 2-YEAR AVAILABILITY OF ALLOTMENTS; EXPENDITURES COUNTED AGAINST OLDEST ALLOTMENTS.—Section 2104(e) of the Social Security Act (42 U.S.C. 1397dd(e)) is amended to read as follows:

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

''(1) IN GENERAL.—Except as provided in the succeeding paragraphs of this subsection, amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for each of fiscal years 2008 through 2012, shall remain available for expenditure by the State only through the end of the succeeding fiscal year for which such amounts are allotted.

''(2) ELIMINATION OF REDISTRIBUTION OF ALLOTMENTS NOT EXPENDED WITHIN 3 YEARS.—Notwithstanding subsection (f), amounts allotted to a State under this section for fiscal years beginning with fiscal year 2008 that remain unexpended as of the end of the second succeeding fiscal year shall not be redistributed to other States and shall revert to the Treasury on October 1 of the third succeeding fiscal year.

''(3) RULE FOR COUNTING EXPENDITURES AGAINST FISCAL YEAR ALLOTMENTS.—Expenditures under the State child health plan made on or after October 1, 2007, shall be counted against allotments for the earliest fiscal year for which funds are available for expenditure under this subsection.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 2104(b)(1) of the Social Security Act (42 U.S.C. 1397dd(b)(1)) is amended by striking ''subsection (d)'' and inserting ''the succeeding subsections of this section''.

(2) Section 2104(f) of such Act (42 U.S.C. 1397dd(f)) is amended by striking ''The'' and inserting ''Subject to subsection (e)(2), the''.

SEC. 103. LIMITATIONS ON MATCHING RATES FOR POPULATIONS OTHER THAN LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.

(a) LIMITATION ON PAYMENTS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATIONS ON MATCHING RATE FOR POPULATIONS OTHER THAN TARGETED LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.—For child health assistance or health benefits coverage furnished in any fiscal year beginning with fiscal year 2008:

''(A) FMAP APPLIED TO PAYMENTS FOR COVERAGE OF CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER ENROLLED IN THE STATE CHILD HEALTH PLAN ON THE DATE OF ENACTMENT OF THE KIDS FIRST ACT AND WHOSE GROSS FAMILY INCOME IS DETERMINED TO EXCEED THE INCOME ELIGIBILITY LEVEL SPECIFIED FOR A TARGETED LOW-INCOME CHILD.—Notwithstanding subsections (b)(1)(B) and (d) of section 2110, in the case of any individual described in subsection (c) of section 105 of the Kids First Act who the State elects to continue to provide child health assistance for under the State child health plan in accordance with the requirements of such subsection, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to such assistance.

''(B) FMAP APPLIED TO PAYMENTS ONLY FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS AND CARETAKER RELATIVES ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—The Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to payments for child health assistance or health benefits coverage provided under the State child health plan for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES ENROLLED UNDER A WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project on the date of enactment of the Kids First Act and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(ii) NONPREGNANT CHILDLESS ADULTS ENROLLED UNDER A WAIVER ON SUCH DATE.—A nonpregnant childless adult enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project described in section 6102(c)(3) of the Deficit Reduction Act of 2005 (42 U.S.C. 1397gg note) on the date of enactment of the Kids First Act and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(iii) NO REPLACEMENT ENROLLEES.—Nothing in clauses (i) or (ii) shall be construed as authorizing a State to provide child health assistance or health benefits coverage under a waiver described in either such clause to a nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child, or a nonpregnant childless adult, who is not enrolled under the waiver on the date of enactment of the Kids First Act.

''(C) NO FEDERAL PAYMENT FOR ANY NEW NONPREGNANT ADULT ENROLLEES OR FOR SUCH ENROLLEES WHO NO LONGER SATISFY INCOME ELIGIBILITY REQUIREMENTS.—Payment shall not be made under this section for child health assistance or other health benefits coverage provided under the State child health plan or under a waiver under section 1115 for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES UNDER A SECTION 1115 WAIVER APPROVED AFTER THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child under a waiver, experimental, pilot, or demonstration project that is approved on or after the date of enactment of the Kids First Act.

''(ii) PARENTS, CARETAKER RELATIVES, AND NONPREGNANT CHILDLESS ADULTS WHOSE FAMILY INCOME EXCEEDS THE INCOME ELIGIBILITY LEVEL SPECIFIED UNDER A SECTION 1115 WAIVER APPROVED PRIOR TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child whose family income exceeds the income eligibility level referred to in subparagraph (B)(i), and any nonpregnant childless adult whose family income exceeds the income eligibility level referred to in subparagraph (B)(ii).

''(iii) NONPREGNANT CHILDLESS ADULTS, PARENTS, OR CARETAKER RELATIVES NOT ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(i) on the date of enactment of the Kids First Act, and any nonpregnant childless adult who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(ii)(I) on such date.

''(D) DEFINITION OF CARETAKER RELATIVE.—In this subparagraph, the term 'caretaker relative' has the meaning given that term for purposes of carrying out section 1931.

''(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as implying that payments for coverage of populations for which the Federal medical assistance percentage (as so determined) is to be substituted for the enhanced FMAP under subsection (a)(1) in accordance with this paragraph are to be made from funds other than the allotments determined for a State under section 2104.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) of the Social Security Act (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

SEC. 104. PROHIBITION ON NEW SECTION 1115 WAIVERS FOR COVERAGE OF ADULTS OTHER THAN PREGNANT WOMEN.

(a) IN GENERAL.—Section 2107(f) of the Social Security Act (42 U.S.C. 1397gg(f)) is amended—

(1) by striking '', the Secretary'' and inserting '':

''(1) The Secretary''; and

(2) by adding at the end the following new paragraphs:

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with

respect to a State after the date of enactment of the Kids First Act that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman whose family income does not exceed the income eligibility level specified for a targeted low-income child in that State under a waiver or project approved as of such date.

''(3) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would waive or modify the requirements of section 2105(c)(8).''.

(b) CLARIFICATION OF AUTHORITY FOR COVERAGE OF PREGNANT WOMEN.—Section 2106 of the Social Security Act (42 U.S.C. 1397ff) is amended by adding at the end the following new subsection:

''(f) NO AUTHORITY TO COVER PREGNANT WOMEN THROUGH STATE PLAN.—For purposes of this title, a State may provide assistance to a pregnant woman under the State child health plan only—

''(1) by virtue of a waiver under section 1115; or

''(2) through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect on the date of enactment of the Kids First Act).''.

(c) ASSURANCE OF NOTICE TO AFFECTED ENROLLEES.—The Secretary of Health and Human Services shall establish procedures to ensure that States provide adequate public notice for parents, caretaker relatives, and nonpregnant childless adults whose eligibility for child health assistance or health benefits coverage under a waiver under section 1115 of the Social Security Act will be terminated as a result of the amendments made by subsection (a), and that States otherwise adhere to regulations of the Secretary relating to procedures for terminating waivers under section 1115 of the Social Security Act.

SEC. 105. STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.

(a) ELIGIBILITY BASED ON GROSS INCOME.—

(1) IN GENERAL.—Section 2110 of the Social Security Act (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.—A State shall determine family income for purposes of determining income eligibility for child health assistance or other health benefits coverage under the State child health plan (or under a waiver of such plan under section 1115) solely on the basis of the gross income (as defined by the Secretary) of the family.''.

(2) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 104(a), is amended by adding at the end the following new paragraph:

''(4) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would waive or modify the requirements of section 2110(d) (relating to determining income eligibility on the basis of gross income) and regulations promulgated to carry out such requirements.''.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate interim final regulations defining gross income for purposes of section 2110(d) of the Social Security Act, as added by subsection (a).

(c) APPLICATION TO CURRENT ENROLLEES.—The interim final regulations promulgated under subsection (b) shall not be used to determine the income eligibility of any individual enrolled in a State child health plan under title XXI of the Social Security Act on the date of enactment of this Act before the date on which such eligibility of the individual is required to be redetermined under the plan as in effect on such date. In the case of any individual enrolled in such plan on such date who, solely as a result of the application of subsection (d) of section 2110 of the Social Security Act (as added by subsection (a)) and the regulations promulgated under subsection (b), is determined to be ineligible for child health assistance under the State child health plan, a State may elect, subject to substitution of the Federal medical assistance percentage for the enhanced FMAP under section 2105(c)(8)(A) of the Social Security Act (as added by section 103(a)), to continue to provide the individual with such assistance for so long as the individual otherwise would be eligible for such assistance and the individual's family income, if determined under the income and resource standards and methodologies applicable under the State child health plan on September 30, 2007, would not exceed the income eligibility level applicable to the individual under the State child health plan.

SEC. 106. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

''(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

''(1) IN GENERAL.—From the amounts appropriated for a fiscal year under subsection (f), subject to paragraph (2), the Secretary shall award grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

''(2) 10 PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts for the fiscal year shall be used by the Secretary for expenditures during the fiscal year to carry out a national enrollment campaign in accordance with subsection (g).

''(b) AWARD OF GRANTS.—

''(1) PRIORITY FOR AWARDING.—

''(A) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

''(i) propose to target geographic areas with high rates of—

''(I) eligible but unenrolled children, including such children who reside in rural areas; or

''(II) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

''(ii) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

''(B) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (f) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

''(2) 2-YEAR AVAILABILITY.—A grant awarded under this section for a fiscal year shall remain available for expenditure through the end of the succeeding fiscal year.

''(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

''(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

''(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

''(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

''(4) an assurance that the eligible entity shall—

''(A) conduct an assessment of the effectiveness of such activities against the performance measures;

''(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments.

''(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

''(d) SUPPLEMENT, NOT SUPPLANT.—Federal funds awarded under this section shall be used to supplement, not supplant, non-Federal funds that are otherwise available for activities funded under this section.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State with an approved child health plan under this title.

''(B) A local government.

''(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

''(D) A Federal health safety net organization.

''(E) A State, national, local, or community-based public or nonprofit private organization.

''(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

''(G) An elementary or secondary school.

''(H) A national, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

''(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

''(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

''(D) any other entity or consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C.

1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

''(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(4) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health or nutrition needs; and

''(F) by providing referral and followup services.

''(f) APPROPRIATION.—

''(1) IN GENERAL.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for the purpose of awarding grants under this section—

''(A) $100,000,000 for each of fiscal years 2008 and 2009;

''(B) $75,000,000 for each of fiscal years 2010 and 2011; and

''(C) $50,000,000 for fiscal year 2012.

''(2) GRANTS IN ADDITION TO OTHER AMOUNTS PAID.—Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

''(g) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2) for a fiscal year, the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

''(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

''(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

''(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

''(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

''(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

''(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.''.

(b) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

''(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH AND ENROLLMENT.—The limitation under subparagraph (A) shall not apply with respect to expenditures for outreach activities under section 2102(c)(1), or for enrollment activities, for children eligible for child health assistance under the State child health plan or medical assistance under the State plan under title XIX.''.

SEC. 107. IMPROVED STATE OPTION FOR OFFERING PREMIUM ASSISTANCE FOR COVERAGE THROUGH PRIVATE PLANS.

(a) IN GENERAL.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)), as amended by section 103(a) is amended by adding at the end the following:

''(9) ADDITIONAL STATE OPTION FOR OFFERING PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph.

''(B) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(i) IN GENERAL.—In this paragraph, the term 'qualified employer sponsored coverage' means a group health plan or health insurance coverage offered through an employer that is—

''(I) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(II) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(III) cost-effective, as determined under clause (ii).

''(ii) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(I) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(II) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(iii) HIGH DEDUCTIBLE HEALTH PLANS INCLUDED.—The term 'qualified employer sponsored coverage' includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on June 28, 2007.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(b) APPLICATION TO MEDICAID.—Section 1906 of the Social Security Act (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(9) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SEC. 108. TREATMENT OF UNBORN CHILDREN.

(a) CODIFICATION OF CURRENT REGULATIONS.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by striking the period at the end and inserting the following: '', and includes, at the option of a State, an unborn child. For purposes of the previous sentence, the term 'unborn child' means a member of the species Homo sapiens, at any stage of development, who is carried in the womb.''.

(b) CLARIFICATIONS REGARDING COVERAGE OF MOTHERS.—Section 2103 of such Act (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

''(g) CLARIFICATIONS REGARDING AUTHORITY TO PROVIDE POSTPARTUM SERVICES AND MATERNAL HEALTH CARE.—Any State that provides child health assistance to an unborn child under the option described in section 2110(c)(1) may—

''(1) continue to provide such assistance to the mother, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends; and

''(2) in the interest of the child to be born, have flexibility in defining and providing services to benefit either the mother or unborn child consistent with the health of both.''.

SEC. 109. 50 PERCENT MATCHING RATE FOR ALL MEDICAID ADMINISTRATIVE COSTS.

Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(1) by striking paragraph (2);

(2) by redesignating paragraph (3)(E) as paragraph (2) and re-locating and indenting it appropriately;

(3) in paragraph (2), as so redesignated, by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), and indenting them appropriately;

(4) by striking paragraphs (3) and (4);

(5) in paragraph (5), by striking ''which are attributable to the offering, arranging, and furnishing'' and inserting ''which are for the medical assistance costs of furnishing'';

(6) by striking paragraph (6);

(7) in paragraph (7), by striking ''subject to section 1919(g)(3)(B),''; and

(8) by redesignating paragraphs (5) and (7) as paragraphs (3) and (4), respectively.

SEC. 110. REDUCTION IN PAYMENTS FOR MEDICAID ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF SUCH PAYMENTS UNDER TANF.

Section 1903 of such Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(7), by striking ''section 1919(g)(3)(B)'' and inserting ''subsection (h)'';

(2) in subsection (a)(2)(D) by inserting '', subject to subsection (g)(3)(C) of such section'' after ''as are attributable to State activities under section 1919(g)''; and

(3) by adding after subsection (g) the following new subsection:

''(h) REDUCTION IN PAYMENTS FOR ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF PAYMENTS UNDER TITLE IV.—Beginning with the calendar quarter commencing October 1, 2007, the Secretary shall reduce the amount paid to each State under subsection (a)(7) for each quarter by an amount equal to ¼ of the annualized amount determined for the Medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2025(k)(2)(B)).''.

SEC. 111. EFFECTIVE DATE.

(a) IN GENERAL.—Subject to subsection (b), the amendments made by this title take effect on October 1, 2007.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State child health plan under title XXI of the Social Security Act or a waiver of such plan under section 1115 of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan or waiver to meet the additional requirements imposed by the amendments made by this title, the State child health plan or waiver shall not be regarded as failing to comply with the requirements of such title XXI solely on the basis of its failure to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this title. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE II—HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY

SEC. 200. SHORT TITLE; PURPOSE.

(a) SHORT TITLE.—This title may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2007''.

(b) PURPOSES.—It is the purpose of this title 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.

Subtitle A—Small Business Health Plans

SEC. 201. 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 2007.

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

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

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

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

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

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

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

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

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

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

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

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

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

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; and

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

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

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

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

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

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

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

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

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

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

''(i) setting contribution rates for the small business health plan based on the claims experience of the plan so long as any variation in such rates complies with the requirements of clause (ii), except that small business health plans shall not be subject to paragraphs (1)(A) and (3) of section 2911(b) of the Public Health Service Act; or

''(ii) varying contribution rates for participating employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of

part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by subtitle B of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

''(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 subtitle B of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

''(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 2007), 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 2007)) 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 section).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

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

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

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

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

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of the Employee Retirement Income Security Act of 1974 (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 2007) (concerning health plan rating and benefits) are met.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (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 the Employee Retirement Income Security Act of 1974 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. 202. 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. 203. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle 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 subtitle within 6 months after the date of the enactment of this Act.

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

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

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

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

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

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

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

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

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

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

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'',

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

Subtitle B—Market Relief

SEC. 211. MARKET RELIEF.

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

''TITLE XXX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 3001. 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. 3011. DEFINITIONS.

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

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

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

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

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

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(5) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the

class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

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

''SEC. 3012. RATING RULES.

''(a) IMPLEMENTATION OF MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the enactment of this title, the Secretary shall promulgate regulations implementing the Model Small Group Rating Rules pursuant to section 3011(b).

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

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

''(2) PREMIUM VARIATION DURING TRANSITION.—

''(A) TRANSITION STATES.—During the transition period described in paragraph (1), small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by less than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the premium variation provision of section 3011(b)(1) of the Model Small Group Rating Rules and shall instead be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1).

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

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

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

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007 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 2007.

''SEC. 3013. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

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

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

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

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

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

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

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

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

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

''SEC. 3014. 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 3013.

''(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. 3015. 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. 3021. 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 3022.

''(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. 3022. 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. 3023. 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 3022(a); or

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

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

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

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

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

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

''SEC. 3024. 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 3023.

''(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. 3025. RULES OF CONSTRUCTION.

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

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

Subtitle C—Harmonization of Health Insurance Standards

SEC. 221. 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. 3031. 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 3032(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 3032(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 3032(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. 3032. HARMONIZED STANDARDS.

''(a) BOARD.—

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

''(2) COMPOSITION.—

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

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

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

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

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

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

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

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

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

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

''(C) Two representatives of consumer organizations.

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

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

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

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

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

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

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

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

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

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

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

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

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

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

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

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

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

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

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

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

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

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

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

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

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

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

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

''(viii) Coordination of market conduct analysis.

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

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

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

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

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

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

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits

under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the Benefit Choice Standards pursuant to section 3022(a).

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

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

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

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

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

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

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

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

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

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

''(2) CERTIFICATION.—

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

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

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

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

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

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

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

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

''(g) PUBLICATION.—

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

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 3033. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle shall supersede any and all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

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

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

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

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

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

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

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

''SEC. 3034. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 3033.

''(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. 3035. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

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

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

TITLE III—HEALTH SAVINGS ACCOUNTS

SEC. 301. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(D) CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS QUALIFIED.—An expense shall not fail to be treated as a qualified medical expense solely because such expense was incurred before the establishment of the health savings account if such expense was incurred—

''(i) during either—

''(I) the taxable year in which the health savings account was established, or

''(II) the preceding taxable year in the case of a health savings account established after the taxable year in which such expense was incurred but before the time prescribed by law for filing the return for such taxable year (not including extensions thereof), and

''(ii) for medical care of an individual during a period that such individual was an eligible individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 302. USE OF ACCOUNT FOR INDIVIDUAL HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.

(a) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 (relating to exceptions) is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'', and by adding at the end the following new clause:

''(v) a high deductible health plan, other than a group health plan (as defined in section 5000(b)(1)).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 303. EXCEPTION TO REQUIREMENT FOR EMPLOYERS TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

(a) GREATER EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES TREATED AS MEETING COMPARABILITY REQUIREMENTS.—Subsection (b) of section 4980G of the Internal Revenue Code of 1986 (relating to failure of employer to make comparable health savings account contributions) is amended to read as follows:

''(b) RULES AND REQUIREMENTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

''(2) TREATMENT OF EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES.—For purposes of this section—

''(A) IN GENERAL.—Any contribution by an employer to a health savings account of an employee who is (or the spouse or any dependent of the employee who is) a chronically ill individual in an amount which is greater than a contribution to a health savings account of a comparable participating employee who is not a chronically ill individual shall not fail to be considered a comparable contribution.

''(B) NONDISCRIMINATION REQUIREMENT.—Subparagraph (A) shall not apply unless the excess employer contributions described in subparagraph (A) are the same for all chronically ill individuals who are similarly situated.

''(C) CHRONICALLY ILL INDIVIDUAL.—For purposes of this paragraph, the term 'chronically ill individual' means any individual whose qualified medical expenses for any taxable year are more than 50 percent greater than the average qualified medical expenses of all employees of the employer for such year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. 304. CERTAIN HEALTH REIMBURSEMENT ARRANGEMENT COVERAGE DISREGARDED COVERAGE FOR HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1)(B)(iii) of the Internal Revenue Code of 1986 is amended by inserting ''or a health reimbursement arrangement'' after ''health flexible a spending arrangement''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of the enactment of this Act.

TITLE IV—STUDY

SEC. 401. STUDY ON TAX TREATMENT OF AND ACCESS TO PRIVATE HEALTH INSURANCE.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of the Treasury shall study various options and make recommendations—

(A) for reforming the tax treatment of health insurance to improve tax equity and increase access to private health care coverage; and

(B) for providing meaningful assistance to low-income individuals and families to purchase private health insurance.

(2) CONSIDERATION OF VARIOUS OPTIONS.—In carrying out the study under paragraph (1), the Secretary of the Treasury shall consider—

(A) options which rely on changes to Federal law not included in the Internal Revenue Code of 1986;

(B) options which have a goal of minimizing Federal Government outlays;

(C) options which minimize tax increases;

(D) at least one option which retains the Federal tax exclusion for employer-provided health coverage;

(E) at least one option which is budget neutral; and

(F) at least one option which maintains the current distribution of the Federal income tax burden.

(b) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of the Treasury shall report the results of the study and the recommendations required under subsection (a) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

SA 3065. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 613 of the proposed House amendment to the text.

SA 3066. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 615 of the House amendment to the text.

SA 3067. Mrs. DOLE submitted an amendment intended to be proposed by her to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title VI insert the following:

SEC. ___. BUDGET POINT OF ORDER AGAINST LEGISLATION THAT RAISES EXCISE TAX RATES.

Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''POINT OF ORDER AGAINST RAISES IN EXCISE TAX RATES

''SEC. 316. (a) IN GENERAL.—It shall not be in order in the Senate to consider any bill, resolution, amendment, amendment between Houses, motion, or conference report that includes a Federal excise tax rate increase which disproportionately affects taxpayers with earned income of less than 200 percent of the Federal poverty level, as determined by the Joint Committee on Taxation. In this subsection, the term 'Federal excise tax rate increase' means any amendment to any section in subtitle D or E of the Internal Revenue Code of 1986, that imposes a new percentage or amount as a rate of tax and thereby increases the amount of tax imposed by any such section.

''(b) SUPERMAJORITY WAIVER AND APPEAL.—

''(1) WAIVER.—This section may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(2) APPEAL.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.''.

SA 3068. Mr. REID (for Mr. OBAMA (for himself, Mr. BOND, Mr. LIEBERMAN, Mrs. BOXER, and Mrs. MCCASKILL)) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle H of title V, add the following:

SEC. 594. ADMINISTRATIVE SEPARATIONS OF MEMBERS OF THE ARMED FORCES FOR PERSONALITY DISORDER.

(a) CLINICAL REVIEW OF ADMINISTRATIVE SEPARATIONS BASED ON PERSONALITY DISORDER.—

(1) TEMPORARY MORATORIUM ON SEPARATIONS OF CERTAIN MEMBERS.—Not later than 30 days after the date of the enactment of this Act, and continuing until the Secretary of Defense submits to Congress the report required by subsection (b) and the Comptroller General of the United States submits to Congress the report required by subsection (c), a covered member of the Armed Forces may not, except as provided in paragraph (2), be administratively separated from the Armed Forces on the basis of a personality disorder.

(2) CLINICAL REVIEW OF PROPOSED SEPARATIONS BASED ON PERSONALITY DISORDER.—

(A) IN GENERAL.—A covered member of the Armed Forces may be administratively separated from the Armed Forces on the basis of

a personality disorder under this paragraph if a clinical review of the case is conducted by a senior officer in the office of the Surgeon General of the Armed Force concerned who is a credentialed mental health provider and who is fully qualified to review cases involving maladaptive behavior (personality disorder), diagnosis and treatment of post-traumatic stress disorder, or other mental health conditions.

(B) PURPOSES OF REVIEW.—The purposes of the review with respect to a member under subparagraph (A) are as follows:

(i) To determine whether the diagnosis of personality order in the member is correct and fully documented.

(ii) To determine whether evidence of other mental health conditions (including depression, post-traumatic stress disorder, substance abuse, or traumatic brain injury) resulting from service in a combat zone may exist in the member which indicate that the separation of the member from the Armed Forces on the basis of a personality disorder is inappropriate pending diagnosis and treatment, and, if so, whether initiation of medical board procedures for the member is warranted.

(b) SECRETARY OF DEFENSE REPORT ON ADMINISTRATIVE SEPARATIONS BASED ON PERSONALITY DISORDER.—

(1) REPORT REQUIRED.—Not later than April 1, 2008, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on all cases of administrative separation from the Armed Forces of covered members of the Armed Forces on the basis of a personality disorder.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces have been separated from the Armed Forces on the basis of a personality disorder, and an identification of the various forms of personality order forming the basis for such separations.

(B) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces who have served in Iraq and Afghanistan since October 2001 have been separated from the Armed Forces on the basis of a personality disorder, and the identification of the various forms of personality disorder forming the basis for such separations.

(C) A summary of the policies, by Armed Forces, controlling administrative separations of members of the Armed Forces based on personality disorder, and an evaluation of the adequacy of such policies for ensuring that covered members of the Armed Forces who may be eligible for disability evaluation due to mental health conditions are not separated from the Armed Forces prematurely or unjustly on the basis of a personality order.

(D) A discussion of measures being implemented to ensure that members of the Armed Forces who should be evaluated for disability separation or retirement due to mental health conditions are not prematurely or unjustly processed for separation from the Armed Forces on the basis of a personality disorder, and recommendations regarding how members of the Armed Forces who may have been so separated from the Armed Forces should be provided with expedited review by the applicable board for the correction of military records.

(c) COMPTROLLER GENERAL REPORT ON POLICIES ON ADMINISTRATIVE SEPARATION BASED ON PERSONALITY DISORDER.—

(1) REPORT REQUIRED.—Not later than June 1, 2008, the Comptroller General shall submit to Congress a report on the policies and procedures of the Department of Defense and of the military departments relating to the separation of members of the Armed Forces based on a personality disorder.

(2) ELEMENTS.—The report required by paragraph (1) shall—

(A) include an audit of a sampling of cases to determine the validity and clinical efficacy of the policies and procedures referred to in paragraph (1) and the extent, if any, of the divergence between the terms of such policies and procedures and the implementation of such policies and procedures; and

(B) include a determination by the Comptroller General of whether, and to what extent, the policies and procedures referred to in paragraph (1)—

(i) deviate from standard clinical diagnostic practices and current clinical standards; and

(ii) provide adequate safeguards aimed at ensuring that members of the Armed Forces who suffer from mental health conditions (including depression, post-traumatic stress disorder, or traumatic brain injury) resulting from service in a combat zone are not prematurely or unjustly separated from the Armed Forces on the basis of a personality disorder.

(d) COVERED MEMBER OF THE ARMED FORCES DEFINED.—In this section, the term ''covered member of the Armed Forces''includes the following:

(1) Any member of a regular component of the Armed Forces of the Armed Forces who has served in Iraq or Afghanistan since October 2001.

(2) Any member of the Selected Reserve of the Ready Reserve of the Armed Forces who served on active duty in Iraq or Afghanistan since October 2001.

SA 3069. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title XI, add the following:

SEC. 1107. FEDERAL EMPLOYEES RETIREMENT SYSTEM AGE AND RETIREMENT TREATMENT FOR CERTAIN RETIREES OF THE ARMED FORCES.

(a) INCREASE IN MAXIMUM AGE LIMIT FOR POSITIONS SUBJECT TO FERS.—

(1) IN GENERAL.—Section 3307(e) of title 5, United States Code, is amended—

(A) by striking ''(e) The'' and inserting ''(e)(1) Except as provided in paragraph (2), the''; and

(B) by adding at the end the following:

''(2) The maximum age limit for an original appointment to a position as a law enforcement officer (as defined by section 8401(17)) shall be 47 years of age, in the case of an individual who, before the effective date of such appointment—

''(A) was discharged or released from active duty in the armed forces under honorable conditions; and

''(B) was a member of the Armed Services retired for age or years of service.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to appointments made on or after the date of the enactment of this Act.

(b) ELIGIBILITY FOR ANNUITY.—Section 8412(d) of title 5, United States Code, is amended—

(1) in paragraph (1), by striking ''or'' at the end;

(2) in paragraph (2), by adding ''or'' at the end; and

(3) by inserting after paragraph (2) the following:

''(3) after completing 10 years of service as a law enforcement officer, if such employee—

''(A) is originally appointed to a position as a law enforcement officer after the date of enactment of the National Defense Authorization Act for Fiscal Year 2008;

''(B) performs such 10 years of service after that original appointment;

''(C) was discharged or released from active duty in the armed forces under honorable conditions before such date of appointment; and

''(D) was a member of the Armed Services retired for age or years of service before such date of appointment, or''.

(c) MANDATORY SEPARATION.—Section 8425(b)(1) of title 5, United States Code, is amended in the first sentence by inserting '', except that a law enforcement officer eligible for retirement under 8412(d)(3) shall be separated from service on the last day of the month in which that employee becomes 57 years of age'' before the period.

(d) COMPUTATION OF BASIC ANNUITY.—Section 8415(d) of title 5, United States Code, is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(2) by striking ''The annuity'' and inserting ''(1) Except as provided under paragraph (2), the annuity''

(3) by adding at the end the following:

''(2) The annuity of an employee retiring under section 8412(d)(3) is—

''(A) 1 7/10 percent of that individual's average pay multiplied by—

''(i) the 10 years of service described under section 8412(d)(3)(B); and

''(ii) so much of such individual's total service (other than the 10 years of service described under clause (i) of this subparagraph) as does not exceed 10 years; plus

''(B) 1 percent of that individual's average pay multiplied by so much of such individual's total service as exceeds 20 years.''.

SA 3070. Mr. SESSIONS submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title I, add the following:

SEC. 115. M4 CARBINE RIFLE.

(a) FINDINGS.—Congress makes the following findings:

(1) The members of the Armed Forces are entitled to the best individual combat weapons available in the world today.

(2) Full and open competition in procurement is required by law, and is the most effective way of selecting the best individual combat weapons for the Armed Forces at the best price.

(3) The M4 carbine rifle is currently the individual weapon of choice for the Army, and it is procured through a sole source contract.

(4) The M4 carbine rifle has been proven in combat and meets or exceeds the existing requirements for carbines.

(5) The Army Training and Doctrine Command is conducting a full Capabilities Based Assessment (CBA) of the small arms of the Army which will determine whether or not

gaps exist in the current capabilities of such small arms and inform decisions as to whether or not a new individual weapon is required to address such gaps.

(b) REPORT ON CAPABILITIES BASED ASSESSMENT.—Not later than 90 days after the date of the enactment of this Act, the Secretary of the Army shall submit to the congressional defense committees a report on the Capabilities Based Assessment of the small arms of the Army referred to in subsection (a)(5).

(c) COMPETITION FOR NEW INDIVIDUAL WEAPON.—

(1) COMPETITION REQUIRED.—In the event the Capabilities Based Assessment identifies gaps in the current capabilities of the small arms of the Army and the Secretary of the Army determines that a new individual weapon is required to address such gaps, the Secretary shall procure the new individual weapon through one or more contracts entered into after full and open competition described in paragraph (2).

(2) FULL AND OPEN COMPETITION.—The full and open competition described in this paragraph is full and open competition among all responsible manufacturers that—

(A) is open to all developmental item solutions and nondevelopmental item (NDI) solutions; and

(B) provides for the award of the contract or contracts concerned based on selection criteria that reflect the key performance parameters and attributes identified in an Army-approved service requirements document.

(d) REPORT REQUIRED.—Not later than 120 days after the date of the enactment of this Act, Secretary of Defense shall submit to the congressional defense committees a report on the feasibility and advisability of each of the following:

(1) The certification of a Joint Enhanced Carbine requirement that does not require commonality with currently fielded weapons.

(2) Contracting for a nondevelopmental carbine in lieu of a developmental program intended to meet the proposed Joint Enhanced Carbine requirement.

(3) The reprogramming of funds for the procurement of small arms from the procurement of M4 carbines to the procurement of Joint Enhanced Carbines authorized only as the result of competition.

(4) The use of rapid equipping authority to procure weapons under $2,000 per unit that meet service-approved requirements, with such weapons being nondevelopmental items selected through full and open competition.

SA 3071. Mr. REID proposed an amendment to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; as follows:

At the end of the amendment add the following:

This section shall take effect 3 days after date of enactment.

SA 3072. Mr. REID proposed an amendment to amendment SA 3071 proposed by Mr. REID to the bill H.R. 976, to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; as follows:

In the amendment strike 3 and insert 1.

SA 3073. Mr. REID (for Mr. OBAMA (for himself and Mr. WHITEHOUSE)) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle E of title VIII, add the following:

SEC. 876. TRANSPARENCY AND ACCOUNTABILITY IN MILITARY AND SECURITY CONTRACTING.

(a) REPORTS ON IRAQ AND AFGHANISTAN CONTRACTS.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Defense, the Secretary of State, the Secretary of the Interior, the Administrator of the United States Agency for International Development, and the Director of National Intelligence shall each submit to Congress a report that contains the information, current as of the date of the enactment of this Act, as follows:

(1) The number of persons performing work in Iraq and Afghanistan under contracts (and subcontracts at any tier) entered into by departments and agencies of the United States Government, including the Department of Defense, the Department of State, the Department of the Interior, and the United States Agency for International Development, respectively, and a brief description of the functions performed by these persons.

(2) The companies awarded such contracts and subcontracts.

(3) The total cost of such contracts.

(4) A method for tracking the number of persons who have been killed or wounded in performing work under such contracts.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Secretary of Defense, the Secretary of State, the Secretary of the Interior, the Administrator of the United States Agency for International Development, and the Director of National Intelligence should make their best efforts to compile the most accurate accounting of the number of civilian contractors killed or wounded in Iraq and Afghanistan since October 1, 2001.

(c) DEPARTMENT OF DEFENSE REPORT ON STRATEGY FOR AND APPROPRIATENESS OF ACTIVITIES OF CONTRACTORS UNDER DEPARTMENT OF DEFENSE CONTRACTS IN IRAQ, AFGHANISTAN, AND THE GLOBAL WAR ON TERROR.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Defense shall submit to Congress a report setting forth the strategy of the Department of Defense for the use of, and a description of the activities being carried out by, contractors and subcontractors working in Iraq and Afghanistan in support of Department missions in Iraq, Afghanistan, and the Global War on Terror, including its strategy for ensuring that such contracts do not—

(1) have private companies and their employees performing inherently governmental functions; or

(2) place contractors in supervisory roles over United States Government personnel.

SA 3074. Mr. SPECTER (for himself and Mr. CASEY) submitted an amendment intended to be proposed by him to the joint resolution H.J. Res. 52, making continuing appropriations for the fiscal year 2008, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ____. TWO-YEAR EXTENSION OF THE RECLASSIFICATION OF CERTAIN HOSPITALS UNDER THE MEDICARE PROGRAM.

(a) EXTENSION OF TAX RELIEF AND HEALTH CARE ACT PROVISION.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note) is amended by striking ''September 30, 2007'' and inserting ''September 30, 2009''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of such section 106.

(b) EXTENSION OF SPECIAL EXCEPTION RECLASSIFICATIONS.—Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a special exception reclassification of its wage index for purposes of such section (made under the authority of subsection (d)(5)(I)(i) of such section and contained in the final rule promulgated by the Secretary of Health and Human Services in the Federal Register on August 11, 2004 (69 Fed. Reg. 49107)) would (but for this subsection) expire on September 30, 2007, such special exception reclassification of such hospital shall be extended through September 30, 2009. The previous sentence shall not be effected in a budget-neutral manner.

SA 3075. Mr. BIDEN (for himself, Mr. GRAHAM, Mr. CASEY, Mr. SANDERS, Mr. BROWN, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2011 proposed by Mr. NELSON of Nebraska (for Mr. LEVIN) to the bill H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title XV, add the following:

SEC. 1535. IMPROVISED EXPLOSIVE DEVICE PROTECTION FOR MILITARY VEHICLES.

(a) PROCUREMENT OF ADDITIONAL MINE RESISTANT AMBUSH PROTECTED VEHICLES.—

(1) ADDITIONAL AMOUNT FOR ARMY OTHER PROCUREMENT.—The amount authorized to be appropriated by section 1501(5) for other procurement for the Army is hereby increased by $23,600,000,000.

(2) AVAILABILITY FOR PROCUREMENT OF ADDITIONAL MRAP VEHICLES.—Of the amount authorized to be appropriated by section 1501(5) for other procurement for the Army, as increased by paragraph (1), $23,600,000,000 may be available for the procurement of 15,200 Mine Resistant Ambush Protected (MRAP) Vehicles.

(b) REPORT.—Not later than 30 days after the date of the enactment of this Act, and every 30 days thereafter until the date that is two years after the date of the enactment of this Act, the Secretary of Defense shall submit to the congressional defense committees a report that includes the following:

(1) The current status of efforts to procure and deploy Mine Resistant Ambush Protected vehicles, including the following:

(A) The number of such vehicles procured, and the number of such vehicles deployed, as of the date of such report.

(B) Current plans for increasing the procurement and deployment of such vehicles.

(C) For each on-going contract for the procurement of such vehicles, the contract delivery target for such contract.

(D) For each contract described in subparagraph (C), the number of such vehicles delivered under such contract as of the date of such report.

(E) A description of the obstacles or problems, if any, faced by current contractors for the delivery of such vehicles and by the program for procurement and deployment of such vehicles in general.

(F) Any recommendations for legislative or administrative action that the Secretary considers appropriate to accelerate procurement and deployment of such vehicles.

(G) Any recommendations, including recommendations for additional legislative or administrative action, that the Secretary considers appropriate to enhance non-vehicle protection against improvised explosive devices for members of the Armed Forces.

(2) The status of current efforts to procure and deploy explosively formed penetrator protection for vehicles, including the following:

(A) The amount of such protection procured, and the amount of such protection deployed, as of the date of such report.

(B) Current plans for increasing the procurement and deployment of such protection.

(C) For each on-going contract for the procurement of such protection, the contract delivery target for such contract.

(D) For each contract described in subparagraph (C), the amount of such protection delivered under such contract as of the date of such report.

(E) A description of the obstacles or problems, if any, faced by current contractors for the delivery of such protection and by the program for procurement and deployment of such protection in general.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on September 26, 2007, at 9:30 a.m., in order to conduct a hearing entitled on ''The Role and Impact of Credit Rating Agencies on the Subprime Credit Markets.''

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to hold a hearing during the session of the Senate on Wednesday, September 26, 2007, at 10 a.m. in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on S.1543, a bill to establish a national geothermal initiative to encourage increased production of energy from geothermal resources by creating a program of geothermal research, development, demonstration and commercial application to support the achievement of a national geothermal energy goal.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet during the session of the Senate on Wednesday, September 26, 2007 at 9:30 a.m. in room 406 of the Dirksen Senate Office Building in order to conduct a hearing entitled, ''An Examination of the Impacts of Global Warming on the Chesapeake Bay.''

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

COMMITTEE ON FINANCE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Wednesday, September 26, 2007, at 10 a.m., in room SD–215 of the Dirksen Senate Office Building, to hear testimony on the ''Offshore Tax Issues: Reinsurance and Hedge Funds''.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet on Wednesday, September 26, 2007, at 10 a.m. for a business meeting to consider pending committee business.

Agenda

Nomination

The Honorable Julie L. Myers to be Assistant Secretary, U.S. Department of Homeland Security.

Postal Naming Bills

H.R. 2654, to designate the facility of the United States Postal Service located at 202 South Dumont Avenue in Woonsocket, South Dakota, as the ''Eleanor McGovern Post Office Building;''

H.R. 2467, to designate the facility of the United States Postal Service located at 69 Montgomery Street in Jersey City, New Jersey, as the ''Frank J. Guarini Post Office Building;''

H.R. 2587, to designate the facility of the United States Postal Service located at 555 South 3rd Street Lobby in Memphis, Tennessee, as the ''Kenneth T. Whalum, Sr. Post Office Building;''

H.R. 2778, to designate the facility of the United States Postal Service located at 3 Quaker Ridge Road in New Rochelle, New York, as the ''Robert Merrill Postal Station;''

H.R. 2825, to designate the facility of the United States Postal Service located at 326 South Main Street in Princeton, Illinois, as the ''Owen Lovejoy Princeton Post Office Building;''

H.R. 3052, to designate the facility of the United States Postal Service located at 954 Wheeling Avenue in Cambridge, Ohio, as the ''John Herschel Glenn Jr. Post Office Building;''

H.R. 3106/S. 2023, to designate the facility of the United States Postal Service located at 805 Main Street in Ferdinand, Indiana, as the ''Staff Sergeant David L. Nord Post Office;''

H.R. 2765, to designate the facility of the United States Postal Service located at 44 North Main Street in Hughesville, Pennsylvania, as the ''Master Sergeant Sean Michael Thomas Post Office.''

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

COMMITTEE ON THE JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate Committee on the Judiciary be authorized to meet in order to conduct an Executive Nomination hearing on Wednesday, September 26, 2007 at 2:30 p.m. in the Dirksen Senate Office Building room 226.

Witness list:

Michael J. Sullivan to be Director, Bureau of Alcohol, Tobacco, Firearms and Explosives

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

COMMITTEE ON RULES AND ADMINISTRATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Wednesday, September 26, 2007, at 10 a.m. to conduct an executive business meeting to consider on the Nomination of Robert C. Tapella of Virginia, to be Public Printer, Government Printing Office; and the nominations of Steven T. Walther of Nevada, David M. Mason of Virginia, Robert D. Lenhard of Maryland, and Hans von Spakovsky of Georgia to be members of the Federal Election Commission.

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

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Small Business and Entrepreneurship be authorized to meet during the session of the Senate in order to conduct a hearing entitled ''Improving Internet Access to Help Small Business Compete in a Global Economy,'' on Wednesday, September 26, 2007, beginning at 10 a.m., in room 428A of the Russell Senate Office Building.

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

ORDER FOR STAR PRINT

Mr. REID. Mr. President, I ask unanimous consent that Senate report 110–184 be star printed with the changes at the desk.

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

AUTHORIZATION FOR DOCUMENT PRODUCTION

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to S. Res. 333.