

109<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 1955

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

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 2005

Mr. KIND (for himself, Mr. COOPER, Mr. WU, Mr. EMANUEL, Mr. KENNEDY of Rhode Island, Mr. SMITH of Washington, Mr. McDERMOTT, Mr. ANDREWS, Mr. VAN HOLLEN, Mr. DAVIS of Alabama, Mr. FORD, Mr. DICKS, Mr. ALLEN, and Mr. PRICE of North Carolina) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Education and the Workforce and Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

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

1        *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

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

4        (a) SHORT TITLE.—This Act may be cited as the  
5 “Small Employers Health Benefits Program Act of 2005”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Definitions.
- Sec. 3. Health insurance coverage for non-federal employees.
- Sec. 4. Contract requirement.
- Sec. 5. Eligibility.
- Sec. 6. Alternative conditions to Federal employee plans.
- Sec. 7. Encouraging participation by carriers through adjustments for risk.
- Sec. 8. Encouraging participation by carriers through reinsurance.
- Sec. 9. Contingency reserve fund.
- Sec. 10. Employer participation.
- Sec. 11. Administration through regional administrative entities.
- Sec. 12. Coordination with social security benefits.
- Sec. 13. Public education campaign.
- Sec. 14. Appropriations.
- Sec. 15. Refundable credit for small business employee health insurance ex-  
 penses.
- Sec. 16. Extension of pay-as-you-go requirement.
- Sec. 17. Effective date.

3 **SEC. 2. DEFINITIONS.**

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

8 (b) OTHER TERMS.—In this Act:

9 (1) EMPLOYEE.—The term “employee” has the  
 10 meaning given such term under section 3(6) of the  
 11 Employee Retirement Income Security Act of 1974  
 12 (29 U.S.C. 1002(6)). Such term shall not include an  
 13 employee of the Federal Government.

14 (2) EMPLOYER.—The term “employer” has the  
 15 meaning given such term under section 3(5) of the  
 16 Employee Retirement Income Security Act of 1974  
 17 (29 U.S.C. 1002(5)), except that such term shall in-

1       clude only employers who employed an average of at  
2       least 1 but not more than 100 employees on busi-  
3       ness days during the year preceding the date of ap-  
4       plication. Such term shall not include the Federal  
5       Government.

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

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

12          (5) PARTICIPATING EMPLOYER.—The term  
13       “participating employer” means an employer that—

14           (A) elects to provide health insurance cov-  
15       erage under this Act to its employees; and

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

18          (c) APPLICATION OF CERTAIN RULES IN DETER-  
19       MINATION OF EMPLOYER SIZE.—For purposes of sub-  
20       section (b)(2):

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

1           (2) EMPLOYERS NOT IN EXISTENCE IN PRE-  
2           CEDING YEAR.—In the case of an employer which  
3           was not in existence for the full year prior to the  
4           date on which the employer applies to participate,  
5           the determination of whether such employer meets  
6           the requirements of subsection (b)(2) shall be based  
7           on the average number of employees that it is rea-  
8           sonably expected such employer will employ on busi-  
9           ness days in the employer's first full year.

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

13           (d) WAIVER AND CONTINUATION OF PARTICIPA-  
14           TION.—

15           (1) WAIVER.—The Office may waive the limita-  
16           tions relating to the size of an employer which may  
17           participate in the health insurance program estab-  
18           lished under this Act on a case by case basis if the  
19           Office determines that such employer makes a com-  
20           pelling case for such a waiver. In making determina-  
21           tions under this paragraph, the Office may consider  
22           the effects of the employment of temporary and sea-  
23           sonal workers and other factors.

24           (2) CONTINUATION OF PARTICIPATION.—An  
25           employer participating in the program under this

1 Act that experiences an increase in the number of  
2 employees so that such employer has in excess of  
3 100 employees, may not be excluded from participa-  
4 tion solely as a result of such increase in employees.

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

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

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

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

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

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

23 (3) any other change that would adversely af-  
24 fect the coverage afforded under such chapter 89 to

1 employees and annuitants and members of family  
2 under that chapter.

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

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

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

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

19 **SEC. 4. CONTRACT REQUIREMENT.**

20 (a) IN GENERAL.—The Office may enter into con-  
21 tracts with qualified carriers offering health benefits plans  
22 of the type described in section 8903 or 8903a of title  
23 5, United States Code, without regard to section 5 of title  
24 41, United States Code, or other statutes requiring com-  
25 petitive bidding, to provide health insurance coverage to

1 employees of participating employers under this Act. Each  
2 contract shall be for a uniform term of at least 1 year,  
3 but may be made automatically renewable from term to  
4 term in the absence of notice of termination by either  
5 party. In entering into such contracts, the Office shall en-  
6 sure that health benefits coverage is provided for individ-  
7 uals only, married individuals without children, and fami-  
8 lies.

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

11 (1) is licensed to offer health benefits plan cov-  
12 erage in each State in which the plan is offered; and

13 (2) meets such other requirements as deter-  
14 mined appropriate by the Office.

15 (c) STATEMENT OF BENEFITS.—

16 (1) IN GENERAL.—Each contract under this  
17 Act shall contain a detailed statement of benefits of-  
18 fered and shall include information concerning such  
19 maximums, limitations, exclusions, and other defini-  
20 tions of benefits as the Office considers necessary or  
21 desirable.

22 (2) NATIONWIDE PLAN.—The Office shall de-  
23 velop a benefit package that shall be offered in the  
24 case of a contract for a health benefit plan that is  
25 to be offered on a nationwide basis.

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

9 (e) CONVERSION.—

10 (1) IN GENERAL.—A contract may not be made  
11 or a plan approved under this section if the carrier  
12 under such contract or plan does not offer to each  
13 enrollee whose enrollment in the plan is ended, ex-  
14 cept by a cancellation of enrollment, a temporary ex-  
15 tension of coverage during which the individual may  
16 exercise the option to convert, without evidence of  
17 good health, to a nongroup contract providing health  
18 benefits. An enrollee who exercises this option shall  
19 pay the full periodic charges of the nongroup con-  
20 tract.

21 (2) NONCANCELLABLE.—The benefits and cov-  
22 erage made available under paragraph (1) may not  
23 be canceled by the carrier except for fraud, over-in-  
24 surance, or nonpayment of periodic charges.

1           (f) RATES.—Rates charged under health benefits  
2 plans under this Act shall reasonably and equitably reflect  
3 the cost of the benefits provided. Such rates shall be deter-  
4 mined on a basis which, in the judgment of the Office,  
5 is consistent with the lowest schedule of basic rates gen-  
6 erally charged for new group health benefits plans issued  
7 to large employers. The rates determined for the first con-  
8 tract term shall be continued for later contract terms, ex-  
9 cept that they may be readjusted for any later term, based  
10 on past experience and benefit adjustments under the later  
11 contract. Any readjustment in rates shall be made in ad-  
12 vance of the contract term in which they will apply and  
13 on a basis which, in the judgment of the Office, is con-  
14 sistent with the general practice of carriers which issue  
15 group health benefits plans to large employers. Rates  
16 charged for coverage under this Act shall not vary based  
17 on health-status related factors.

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

1 **SEC. 5. ELIGIBILITY.**

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

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

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

11 **SEC. 6. ALTERNATIVE CONDITIONS TO FEDERAL EM-**  
12 **PLOYEE PLANS.**

13 (a) TREATMENT OF EMPLOYEE.—For purposes of  
14 enrollment in a health benefits plan under this Act, an  
15 individual who had coverage under a health insurance plan  
16 and is not a qualified beneficiary as defined under section  
17 4980B(g)(1) of the Internal Revenue Code of 1986 shall  
18 be treated in a similar manner as an individual who begins  
19 employment as an employee under chapter 89 of title 5,  
20 United States Code.

21 (b) PREEXISTING CONDITION EXCLUSIONS.—

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

26 (2) EXCLUSION PERIOD.—

1           (A) IN GENERAL.—A preexisting condition  
2           exclusion under this subsection shall provide for  
3           coverage of a preexisting condition to begin not  
4           later than 6 months after the date on which the  
5           coverage of the individual under a health bene-  
6           fits plan commences, reduced by 1 month for  
7           each month that the individual was covered  
8           under a health insurance plan immediately pre-  
9           ceding the date the individual submitted an ap-  
10          plication for coverage under this Act.

11          (B) LAPSE IN COVERAGE.—For purposes  
12          of this paragraph, a lapse in coverage of not  
13          more than 63 days immediately preceding the  
14          date of the submission of an application for cov-  
15          erage under this Act shall not be considered a  
16          lapse in continuous coverage.

17          (c) RATES AND PREMIUMS.—

18           (1) IN GENERAL.—Rates charged and pre-  
19           miums paid for a health benefits plan under this  
20           Act—

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

23           (B) may be annually adjusted and differ  
24           from such rates charged and premiums paid for

1 the same health benefits plan offered under  
2 chapter 89 of title 5, United States Code;

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

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

8 (2) DETERMINATIONS.—In determining rates  
9 and premiums under this Act, the following provi-  
10 sions shall apply:

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

16 (i) for the geographic area involved if  
17 the adjustment is based on geographical  
18 divisions that are not smaller than a met-  
19 ropolitan statistical area;

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

23 (iii) based on the age of covered indi-  
24 viduals (subject to subparagraph (B)).

25 (B) AGE ADJUSTMENTS.—

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

7 (ii) AGE 65 AND OLDER.—With re-  
8 spect to subparagraph (A)(iii), a carrier  
9 may develop separate rates for covered in-  
10 dividuals who are 65 years of age or older  
11 for whom medicare is the primary payor  
12 for health benefits coverage which is not  
13 covered under medicare.

14 (iii) LIMITATION.—In making an ad-  
15 justment to premium rates under subpara-  
16 graph (A)(iii), a carrier shall ensure that  
17 such adjustment does not result in an av-  
18 erage premium rate applicable to enrollees  
19 under the plan involved that is more than  
20 200 percent of the lowest rate for all age  
21 groups.

22 (d) TERMINATION AND REENROLLMENT.—If an indi-  
23 vidual who is enrolled in a health benefits plan under this  
24 Act terminates the enrollment, the individual shall not be  
25 eligible for reenrollment until the first open enrollment pe-

1 rioid following the expiration of 6 months after the date  
2 of such termination.

3 (e) PREEMPTION.—

4 (1) HEALTH INSURANCE OR PLANS.—

5 (A) IN GENERAL.—Except as provided in  
6 subparagraph (B), the terms of any contract  
7 entered into under this Act that relate to the  
8 nature, provision, or extent of coverage or bene-  
9 fits shall supersede and preempt any State or  
10 local law, or any regulation issued thereunder,  
11 which relates to the nature, provision, or extent  
12 of coverage or benefits.

13 (B) LOCAL PLANS.—With respect to a con-  
14 tract entered into under this Act under which  
15 a carrier will offer health benefits plan coverage  
16 in a limited geographic area, subparagraph (A)  
17 shall not apply to the extent that a mandated  
18 benefit law is in effect in the State in which the  
19 plan is offered. Such mandated benefit law shall  
20 continue to apply to such health benefits plan.

21 (C) RATING RULES.—The rating require-  
22 ments under subsection (c)(2) shall supersede  
23 State rating rules for qualified plans under this  
24 Act.

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

3           (A) any State or local law or regulation ex-  
4 cept those laws and regulations described in  
5 subparagraphs (A) and (C) of paragraph (1);  
6 and

7           (B) State network adequacy laws.

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

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

15           (a) APPLICATION OF RISK CORRIDORS.—

16           (1) IN GENERAL.—This section shall only apply  
17 to carriers with respect to health benefits plans of-  
18 fered under this Act during any of calendar years  
19 2006 through 2010.

20           (2) NOTIFICATION OF COSTS UNDER THE  
21 PLAN.—In the case of a carrier that offers a health  
22 benefits plan under this Act in any of calendar years  
23 2006 through 2010, the carrier shall notify the Of-  
24 fice, before such date in the succeeding year as the  
25 Office specifies, of the total amount of costs incurred

1 in providing benefits under the health benefits plan  
2 for the year involved and the portion of such costs  
3 that is attributable to administrative expenses.

4 (3) ALLOWABLE COSTS DEFINED.—For pur-  
5 poses of this section, the term “allowable costs”  
6 means, with respect to a health benefits plan offered  
7 by a carrier under this Act, for a year, the total  
8 amount of costs described in paragraph (2) for the  
9 plan and year, reduced by the portion of such costs  
10 attributable to administrative expenses incurred in  
11 providing the benefits described in such paragraph.

12 (b) ADJUSTMENT OF PAYMENT.—

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

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

23 (A) COSTS BETWEEN 103 AND 108 PER-  
24 CENT OF TARGET AMOUNT.—If the allowable  
25 costs for the carrier with respect to the health

1 benefits plan involved for the year are greater  
2 than 103 percent, but not greater than 108  
3 percent, of the target amount for the plan and  
4 year, the Office shall reimburse the carrier for  
5 such excess costs through payment to the car-  
6 rier of an amount equal to 75 percent of the  
7 difference between such allowable costs and 103  
8 percent of such target amount.

9 (B) COSTS ABOVE 108 PERCENT OF TAR-  
10 GET AMOUNT.—If the allowable costs for the  
11 carrier with respect to the health benefits plan  
12 involved for the year are greater than 108 per-  
13 cent of the target amount for the plan and  
14 year, the Office shall reimburse the carrier for  
15 such excess costs through payment to the car-  
16 rier in an amount equal to the sum of—

17 (i) 3.75 percent of such target  
18 amount; and

19 (ii) 90 percent of the difference be-  
20 tween such allowable costs and 108 percent  
21 of such target amount.

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

24 (A) COSTS BETWEEN 92 AND 97 PERCENT  
25 OF TARGET AMOUNT.—If the allowable costs for

1 the carrier with respect to the health benefits  
2 plan involved for the year are less than 97 per-  
3 cent, but greater than or equal to 92 percent,  
4 of the target amount for the plan and year, the  
5 carrier shall be required to pay into the contin-  
6 gency reserve fund maintained under section  
7 8909(b)(2) of title 5, United States Code, an  
8 amount equal to 75 percent of the difference  
9 between 97 percent of the target amount and  
10 such allowable costs.

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

19 (i) 3.75 percent of such target  
20 amount; and

21 (ii) 90 percent of the difference be-  
22 tween 92 percent of such target amount  
23 and such allowable costs.

24 (4) TARGET AMOUNT DESCRIBED.—

1 (A) IN GENERAL.—For purposes of this  
2 subsection, the term “target amount” means,  
3 with respect to a health benefits plan offered by  
4 a carrier under this Act in any of calendar  
5 years 2006 through 2010, an amount equal  
6 to—

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

12 (ii) the amount of administrative ex-  
13 penses that the carrier estimates, and the  
14 Office approves, will be incurred by the  
15 carrier with respect to the plan for such  
16 calendar year.

17 (B) SUBMISSION OF TARGET AMOUNT.—  
18 Not later than December 31, 2005, and each  
19 December 31 thereafter through calendar year  
20 2009, a carrier shall submit to the Office a de-  
21 scription of the target amount for such carrier  
22 with respect to health benefits plans provided  
23 by the carrier under this Act.

24 (c) DISCLOSURE OF INFORMATION.—

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

3           (A) that a carrier offering a health benefits  
4 plan under this Act shall provide the Office  
5 with such information as the Office determines  
6 is necessary to carry out this subsection includ-  
7 ing the notification of costs under subsection  
8 (a)(2) and the target amount under subsection  
9 (b)(4)(B); and

10           (B) that the Office has the right to inspect  
11 and audit any books and records of the organi-  
12 zation that pertain to the information regarding  
13 costs provided to the Office under such sub-  
14 sections.

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

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

23           (a) ESTABLISHMENT.—The Office shall establish a  
24 reinsurance fund to provide payments to carriers that ex-  
25 perience one or more catastrophic claims during a year

1 for health benefits provided to individuals enrolled in a  
2 health benefits plan under this Act.

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

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

11 (2) such other information determined appro-  
12 priate by the Office.

13 (c) PAYMENT.—

14 (1) IN GENERAL.—The amount of a payment  
15 from the reinsurance fund to a carrier under this  
16 section for a catastrophic episode of care shall be de-  
17 termined by the Office but shall not exceed an  
18 amount equal to 80 percent of the applicable cata-  
19 strophic claim amount.

20 (2) APPLICABLE CATASTROPHIC CLAIM  
21 AMOUNT.—For purposes of paragraph (1), the appli-  
22 cable catastrophic episode of care amount shall be  
23 equal to the difference between—

24 (A) the amount of the catastrophic claim;

25 and

1 (B) \$50,000.

2 (3) LIMITATION.—In determining the amount  
3 of a payment under paragraph (1), if the amount of  
4 the catastrophic claim exceeds the amount that  
5 would be paid for the health care items or services  
6 involved under title XVIII of the Social Security Act  
7 (42 U.S.C. 1395 et seq.), the Office shall use the  
8 amount that would be paid under such title XVIII  
9 for purposes of paragraph (2)(A).

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

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

15 Beginning on October 1, 2010, the Office may use  
16 amounts appropriated under section 14(a) that remain un-  
17 obligated to establish a contingency reserve fund to pro-  
18 vide assistance to carriers offering health benefits plans  
19 under this Act that experience unanticipated financial  
20 hardships (as determined by the Office).

21 **SEC. 10. EMPLOYER PARTICIPATION.**

22 (a) REGULATIONS.—The Office shall prescribe regu-  
23 lations providing for employer participation under this  
24 Act, including the offering of health benefits plans under  
25 this Act to employees.

1 (b) ENROLLMENT AND OFFERING OF OTHER COV-  
2 ERAGE.—

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

6 (2) PROHIBITION ON OFFERING OTHER COM-  
7 PREHENSIVE HEALTH BENEFIT COVERAGE.—A par-  
8 ticipating employer may not offer a health insurance  
9 plan providing comprehensive health benefit coverage  
10 to employees other than a health benefits plan  
11 that—

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

14 (B) is offered only through the enrollment  
15 process established by the Office under section  
16 3.

17 (3) OFFER OF SUPPLEMENTAL COVERAGE OP-  
18 TIONS.—

19 (A) IN GENERAL.—A participating em-  
20 ployer may offer supplementary coverage op-  
21 tions to employees.

22 (B) DEFINITION.—In subparagraph (A),  
23 the term “supplementary coverage” means ben-  
24 efits described as “excepted benefits” under

1 section 2791(c) of the Public Health Service  
2 Act (42 U.S.C. 300gg-91(c)).

3 (c) **RULE OF CONSTRUCTION.**—Except as provided in  
4 section 15, nothing in this Act shall be construed to re-  
5 quire that an employer make premium contributions on  
6 behalf of employees.

7 **SEC. 11. ADMINISTRATION THROUGH REGIONAL ADMINIS-**  
8 **TRATIVE ENTITIES.**

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

16 (1) Collect and maintain all information relat-  
17 ing to individuals, families, and employers partici-  
18 pating in the program under this Act in the region  
19 served.

20 (2) Receive, disburse, and account for payments  
21 of premiums to participating employers by individ-  
22 uals in the region served, and for payments by par-  
23 ticipating employers to carriers.

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

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

8           (5) The processing of grievances and appeals.

9           (b) APPLICATION.—To be eligible to receive a con-  
10          tract under subsection (a), an entity shall prepare and  
11          submit to the Office an application at such time, in such  
12          manner, and containing such information as the Office  
13          may require.

14          (c) PROCESS.—

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

18           (2) REQUIREMENT.—No contract shall be en-  
19           tered into with any entity under this section unless  
20           the Office finds that such entity will perform its ob-  
21           ligations under the contract efficiently and effec-  
22           tively and will meet such requirements as to finan-  
23           cial responsibility, legal authority, and other matters  
24           as the Office finds pertinent.

1           (3) PUBLICATION OF STANDARDS AND CRI-  
2           TERIA.—The Office shall publish in the Federal  
3           Register standards and criteria for the efficient and  
4           effective performance of contract obligations under  
5           this section, and opportunity shall be provided for  
6           public comment prior to implementation. In estab-  
7           lishing such standards and criteria, the Office shall  
8           provide for a system to measure an entity's perform-  
9           ance of responsibilities.

10           (4) TERM.—Each contract under this section  
11           shall be for a term of at least 1 year, and may be  
12           made automatically renewable from term to term in  
13           the absence of notice by either party of intention to  
14           terminate at the end of the current term, except that  
15           the Office may terminate any such contract at any  
16           time (after such reasonable notice and opportunity  
17           for hearing to the entity involved as the Office may  
18           provide in regulations) if the Office finds that the  
19           entity has failed substantially to carry out the con-  
20           tract or is carrying out the contract in a manner in-  
21           consistent with the efficient and effective adminis-  
22           tration of the program established by this Act.

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

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

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

6           (3) an assurance that the entity will maintain  
7     such records and afford such access thereto as the  
8     Office finds necessary to assure the correctness and  
9     verification of the information and reports under  
10    paragraph (2) and otherwise to carry out the pur-  
11    poses of this Act;

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

16          (5) such other terms and conditions not incon-  
17    sistent with this section as the Office may find nec-  
18    essary or appropriate.

19 **SEC. 12. COORDINATION WITH SOCIAL SECURITY BENE-**  
20 **FITS.**

21       Benefits under this Act shall, with respect to an indi-  
22    vidual who is entitled to benefits under part A of title  
23    XVIII of the Social Security Act, be offered (for use in  
24    coordination with those medicare benefits) to the same ex-

1 tent and in the same manner as if coverage were under  
2 chapter 89 of title 5, United States Code.

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

4 (a) IN GENERAL.—In carrying out this Act, the Of-  
5 fice shall develop and implement an educational campaign  
6 to provide information to employers and the general public  
7 concerning the health insurance program developed under  
8 this Act.

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

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

21 **SEC. 14. APPROPRIATIONS.**

22 (a) MANDATORY APPROPRIATIONS.—There are au-  
23 thorized to be appropriated, and there are appropriated,  
24 to carry out sections 7 and 8—

25 (1) \$4,000,000,000 for fiscal year 2006;

- 1           (2) \$4,000,000,000 for fiscal year 2007;  
2           (3) \$4,000,000,000 for fiscal year 2008;  
3           (4) \$3,000,000,000 for fiscal year 2009; and  
4           (5) \$3,000,000,000 for fiscal year 2010.

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

9   **SEC. 15. REFUNDABLE CREDIT FOR SMALL BUSINESS EM-**  
10                           **PLOYEE HEALTH INSURANCE EXPENSES.**

11           (a) IN GENERAL.—Subpart C of part IV of sub-  
12 chapter A of chapter 1 of the Internal Revenue Code of  
13 1986 (relating to refundable credits) is amended by redес-  
14 ignating section 36 as section 37 and inserting after sec-  
15 tion 35 the following new section:

16   **“SEC. 36. SMALL BUSINESS EMPLOYEE HEALTH INSURANCE**  
17                           **EXPENSES.**

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

22                   “(1) the expense amount described in sub-  
23           section (b), and

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

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

6           “(1) IN GENERAL.—The expense amount de-  
7           scribed in this subsection is the applicable percent-  
8           age of the amount of qualified employee health in-  
9           surance expenses of each qualified employee.

10           “(2) APPLICABLE PERCENTAGE.—For purposes  
11           of paragraph (1)—

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

14           “(i) 25 percent in the case of self-only  
15           coverage,

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

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

21           “(B) BONUS FOR PAYMENT OF GREATER  
22           PERCENTAGE OF PREMIUMS.—The applicable  
23           percentage otherwise specified in subparagraph  
24           (A) shall be increased by 5 percentage points  
25           for each additional 10 percent of the qualified

1 employee health insurance expenses of each  
2 qualified employee exceeding 60 percent which  
3 are paid by the qualified small employer.

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

6 “(1) IN GENERAL.—The expense amount de-  
7 scribed in this subsection is, with respect to the first  
8 credit year of a qualified small employer which is an  
9 eligible employer, 10 percent of the qualified em-  
10 ployee health insurance expenses of each qualified  
11 employee.

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

17 “(3) ELIGIBLE EMPLOYER.—For purposes of  
18 paragraph (1), the term ‘eligible employer’ shall not  
19 include a qualified small employer if, during the 3-  
20 taxable year period immediately preceding the first  
21 credit year, the employer or any member of any con-  
22 trolled group including the employer (or any prede-  
23 cessor of either) established or maintained health in-  
24 surance coverage for substantially the same employ-

1 ees as are the qualified employees to which the  
2 qualified employee health insurance expenses relate.

3 “(d) LIMITATION BASED ON WAGES.—

4 “(1) IN GENERAL.—The percentage which  
5 would (but for this subsection) be taken into account  
6 as the percentage for purposes of subsection (b)(2)  
7 or (c)(1) for the taxable year shall be reduced (but  
8 not below zero) by the percentage determined under  
9 paragraph (2).

10 “(2) AMOUNT OF REDUCTION.—

11 “(A) IN GENERAL.—The percentage deter-  
12 mined under this paragraph is the percentage  
13 which bears the same ratio to the percentage  
14 which would be so taken into account as—

15 “(i) the excess of—

16 “(I) the qualified employee’s  
17 wages at an annual rate during such  
18 taxable year, over

19 “(II) \$25,000, bears to

20 “(ii) \$5,000.

21 “(B) ANNUAL ADJUSTMENT.—For each  
22 taxable year after 2006, the dollar amounts  
23 specified for the preceding taxable year (after  
24 the application of this subparagraph) shall be  
25 increased by the same percentage as the aver-

1           age percentage increase in premiums under the  
2           Federal Employees Health Benefits Program  
3           under chapter 89 of title 5, United States Code  
4           for the calendar year in which such taxable year  
5           begins over the preceding calendar year.

6           “(e) DEFINITIONS.—For purposes of this section—

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

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

13                         “(B) pays or incurs at least 60 percent of  
14                         the qualified employee health insurance ex-  
15                         penses of each qualified employee.

16                 “(2) QUALIFIED EMPLOYEE HEALTH INSUR-  
17          ANCE EXPENSES.—

18                         “(A) IN GENERAL.—The term ‘qualified  
19                         employee health insurance expenses’ means any  
20                         amount paid by an employer for health insur-  
21                         ance coverage under such Act to the extent  
22                         such amount is attributable to coverage pro-  
23                         vided to any employee while such employee is a  
24                         qualified employee.

1           “(B) EXCEPTION FOR AMOUNTS PAID  
2 UNDER SALARY REDUCTION ARRANGEMENTS.—  
3 No amount paid or incurred for health insur-  
4 ance coverage pursuant to a salary reduction  
5 arrangement shall be taken into account under  
6 subparagraph (A).

7           “(3) QUALIFIED EMPLOYEE.—

8           “(A) IN GENERAL.—The term ‘qualified  
9 employee’ means, with respect to any period, an  
10 employee (as defined in section 2(b)(1) of such  
11 Act) of an employer if the total amount of  
12 wages paid or incurred by such employer to  
13 such employee at an annual rate during the  
14 taxable year exceeds \$5,000.

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

19           “(f) CERTAIN RULES MADE APPLICABLE.—For pur-  
20 poses of this section, rules similar to the rules of section  
21 52 shall apply.

22           “(g) CREDITS FOR NONPROFIT ORGANIZATIONS.—  
23 Any credit which would be allowable under subsection (a)  
24 with respect to a qualified small business if such qualified  
25 small business were not exempt from tax under this chap-

1 ter shall be treated as a credit allowable under this sub-  
 2 part to such qualified small business.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Paragraph (2) of section 1324(b) of title  
 5 31, United States Code, is amended by inserting be-  
 6 fore the period “, or from section 36 of such Code”.

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

“36. Small business employee health insurance expenses.

“37. Overpayments of tax.”.

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

14 **SEC. 16. EXTENSION OF PAY-AS-YOU-GO REQUIREMENT.**

15 (a) PURPOSE.—Section 252(a) of the Balanced  
 16 Budget and Emergency Deficit Control Act of 1985 is  
 17 amended by striking “2002” and inserting “2010”.

18 (b) SEQUESTRATION.—Section 252(b)(1) of such Act  
 19 is amended by striking “2002” and inserting “2010”.

20 (c) EXPIRATION.—Section 275(b) of such Act is  
 21 amended by striking “2006” and inserting “2014”.

22 **SEC. 17. EFFECTIVE DATE.**

23 Except as otherwise provided, this Act shall take ef-  
 24 fect on the date of enactment of this Act and shall apply

- 1 to contracts that take effect with respect to calendar year
- 2 2006 and each calendar year thereafter.

○