

110TH CONGRESS
2^D SESSION

S. 2795

To amend the Public Health Service Act to establish a nationwide health insurance purchasing pool for small businesses and the self-employed that would offer a choice of private health plans and make health coverage more affordable, predictable, and accessible.

IN THE SENATE OF THE UNITED STATES

APRIL 2, 2008

Mr. DURBIN (for himself, Ms. SNOWE, Mrs. LINCOLN, and Mr. COLEMAN) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Public Health Service Act to establish a nationwide health insurance purchasing pool for small businesses and the self-employed that would offer a choice of private health plans and make health coverage more affordable, predictable, and accessible.

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.**

4 This Act may be cited as the “Small Business Health
5 Options Program Act of 2008” or the “SHOP Act”.

1 **SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
2 **ACT.**

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

5 **“TITLE XXX—SMALL BUSINESS**
6 **HEALTH OPTIONS PROGRAM**

7 **“SEC. 3001. DEFINITIONS.**

8 “(a) IN GENERAL.—In this title:

9 “(1) ADMINISTRATOR.—The term ‘Adminis-
10 trator’ means the Administrator appointed under
11 section 3002(a).

12 “(2) SMALL BUSINESS HEALTH BOARD.—The
13 term ‘Small Business Health Board’ means the
14 Board established under section 3002(d).

15 “(3) EMPLOYEE.—The term ‘employee’ has the
16 meaning given such term under section 3(6) of the
17 Employee Retirement Income Security Act of 1974
18 (29 U.S.C. 1002(6)). Such term shall not include an
19 employee of the Federal Government.

20 “(4) EMPLOYER.—The term ‘employer’ has the
21 meaning given such term under section 3(5) of the
22 Employee Retirement Income Security Act of 1974
23 (29 U.S.C. 1002(5)), except that such term shall in-
24 clude employers who employed an average of at least
25 1 but not more than 100 employees (who worked an
26 average of at least 35 hours per week) on business

1 days during the year preceding the date of applica-
2 tion, and shall include self-employed individuals with
3 either not less than \$5,000 in net earnings or not
4 less than \$15,000 in gross earnings from self-em-
5 ployment in the preceding taxable year. Such term
6 shall not include the Federal Government.

7 “(5) HEALTH INSURANCE COVERAGE.—The
8 term ‘health insurance coverage’ has the meaning
9 given such term in section 2791.

10 “(6) HEALTH INSURANCE ISSUER.—The term
11 ‘health insurance issuer’ has the meaning given such
12 term in section 2791.

13 “(7) HEALTH STATUS-RELATED FACTOR.—The
14 term ‘health status-related factor’ has the meaning
15 given such term in section 2791(d)(9).

16 “(8) PARTICIPATING EMPLOYER.—The term
17 ‘participating employer’ means an employer that—

18 “(A) elects to provide health insurance cov-
19 erage under this title to its employees; and

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

22 “(b) APPLICATION OF CERTAIN RULES IN DETER-
23 MINATION OF EMPLOYER SIZE.—For purposes of sub-
24 section (a)(3):

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

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

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

18 “(c) WAIVER AND CONTINUATION OF PARTICIPA-
19 TION.—

20 “(1) WAIVER.—The Administrator may waive
21 the limitations relating to the size of an employer
22 which may participate in the health insurance pro-
23 gram established under this title on a case by case
24 basis if the Administrator determines that such em-
25 ployer makes a compelling case for such a waiver. In

1 making determinations under this paragraph, the
2 Administrator may consider the effects of the em-
3 ployment of temporary and seasonal workers and
4 other factors.

5 “(2) CONTINUATION OF PARTICIPATION.—An
6 employer participating in the program under this
7 title that experiences an increase in the number of
8 employees so that such employer has in excess of
9 100 employees, may not be excluded from participa-
10 tion solely as a result of such increase in employees.

11 “(d) TREATMENT OF HEALTH INSURANCE COV-
12 ERAGE AS GROUP HEALTH PLAN.—Health insurance cov-
13 erage offered under this title shall be treated as a group
14 health plan for purposes of applying the Employee Retire-
15 ment Income Security Act of 1974 (29 U.S.C. 1001 et
16 seq.) except to the extent that a provision of this title ex-
17 pressly provides otherwise.

18 “(e) APPLICATION OF HIPAA RULES.—Notwith-
19 standing any provision of State law, the provisions of sub-
20 parts 1, 3, and 4 of part A of title XXVII shall apply
21 to health insurance coverage offered under this title. A
22 State may modify State law as appropriate to provide for
23 the enforcement of such provisions for health insurance
24 coverage offered in the State under this title.

1 **“SEC. 3002. ADMINISTRATION OF SMALL BUSINESS HEALTH**
2 **INSURANCE POOL.**

3 “(a) OFFICE AND ADMINISTRATOR.—The Secretary
4 shall designate an office within the Department of Health
5 and Human Services to administer the program under this
6 title. Such office shall be headed by an Administrator to
7 be appointed by the Secretary.

8 “(b) QUALIFICATIONS.—The Secretary shall ensure
9 that the individual appointed to serve as the Administrator
10 under subsection (a) has an appropriate background with
11 experience in health insurance, business, or health policy.

12 “(c) DUTIES.—The Administrator shall—

13 “(1) enter into contracts with health insurance
14 issuers to provide health insurance coverage to indi-
15 viduals and employees who enroll in health insurance
16 coverage in accordance with this title;

17 “(2) maintain the contracts for health insur-
18 ance policies when an employee elects which health
19 plan offered under this title to enroll in as permitted
20 under section 3007(d)(7);

21 “(3) ensure that health insurance issuers com-
22 ply with the requirements of this title;

23 “(4) ensure that employers meet eligibility re-
24 quirements for participation in the health insurance
25 pool established under this title;

1 “(5) enter into agreements with entities to
2 serve as navigators, as defined in section 3003;

3 “(6) collect premiums from employers and em-
4 ployees and make payments for health insurance
5 coverage;

6 “(7) collect other information needed to admin-
7 ister the program under this title;

8 “(8) compile, produce, and distribute informa-
9 tion (which shall not be subject to review or modi-
10 fication by the States) to employers and employees
11 (directly and through navigators) concerning the
12 open enrollment process, the health insurance cov-
13 erage available through the pool, and standardized
14 comparative information concerning such coverage,
15 which shall be available through an interactive Inter-
16 net website, including a description of the coverage
17 plans available in each State and comparative infor-
18 mation, about premiums, index rates, benefits, qual-
19 ity, and consumer satisfaction under such plans;

20 “(9) provide information to health insurance
21 issuers, including, at the discretion of the Adminis-
22 trator, notification when proposed rates are not in a
23 competitive range;

24 “(10) conduct public education activities (di-
25 rectly and through navigators) to raise the aware-

1 ness of the public of the program under this title
2 and the associated tax credit under the Internal
3 Revenue Code of 1986;

4 “(11) develop methods to facilitate enrollment
5 in health insurance coverage under this title, includ-
6 ing through the use of the Internet;

7 “(12) if appropriate, enter into contracts for
8 the performance of administrative functions under
9 this title as permitted under section 3009;

10 “(13) carefully consider benefit recommenda-
11 tions that are endorsed by at least two-thirds of the
12 members of the Small Business Health Board;

13 “(14) establish and administer a contingency
14 fund for risk corridors as provided for in section
15 3008; and

16 “(15) carry out any other activities necessary to
17 administer this title.

18 “(d) LIMITATIONS.—The Administrator shall not—

19 “(1) negotiate premiums with participating
20 health insurance issuers; or

21 “(2) exclude health insurance issuers from par-
22 ticipating in the program under this title except for
23 violating contracts or the requirements of this title.

24 “(e) SMALL BUSINESS HEALTH BOARD.—

1 “(1) IN GENERAL.—There shall be established
2 a Small Business Health Board to monitor the im-
3 plementation of the program under this title and to
4 make recommendations to the Administrator con-
5 cerning improvements in the program.

6 “(2) APPOINTMENT.—The Comptroller General
7 shall appoint 13 individuals who have expertise in
8 health care benefits, financing, economics, actuarial
9 science or other related fields, to serve as members
10 of the Small Business Health Board. In appointing
11 members under the preceding sentence, the Comp-
12 troller General shall ensure that such members in-
13 clude—

14 “(A) a mix of different types of profes-
15 sionals;

16 “(B) a broad geographic representation;

17 “(C) not less than 3 individuals with an
18 employee perspective;

19 “(D) not less than 3 individuals with a
20 small business perspective, at least 1 of whom
21 shall have a self-employed perspective; and

22 “(E) not less than 1 individual with a
23 background in insurance regulation.

24 “(3) TERMS.—Members of the Small Business
25 Health Board shall serve for a term of 3 years, such

1 terms to end on March 15 of the applicable year, ex-
2 cept as provided in paragraph (4). The Comptroller
3 General shall stagger the terms for members first
4 appointed. A member may be reappointed after the
5 expiration of a term. A member may serve after ex-
6 piration of a term until a successor has been ap-
7 pointed.

8 “(4) SMALL BUSINESS REPRESENTATIVES.—
9 Beginning on March 16, 2012, 3 of the individuals
10 the Comptroller General appoints to the Small Busi-
11 ness Health Board shall be representatives of the 3
12 navigators through which the largest number of indi-
13 viduals have enrolled for health insurance coverage
14 over the previous 2-year period. Such appointees
15 shall serve for 1 year. The Comptroller General shall
16 consider for appointment in years prior to the date
17 specified in this paragraph, individuals who are rep-
18 resentatives of entities that may serve as navigators.

19 “(5) CHAIRPERSON; VICE CHAIRPERSON.—The
20 Comptroller General shall designate a member of the
21 Small Business Health Board, at the time of ap-
22 pointment of such member, to serve as Chairperson
23 and a member to serve as Vice Chairperson for the
24 term of the appointment, except that in the case of
25 a vacancy of either such position, the Comptroller

1 General may designate another member to serve in
2 such position for the remainder of such member's
3 term.

4 “(6) COMPENSATION.—While serving on the
5 business of the Small Business Health Board (in-
6 cluding travel time), a member of the Small Busi-
7 ness Health Board shall be entitled to compensation
8 at the per diem equivalent of the rate provided for
9 level IV of the Executive Schedule under section
10 5315 of title 5, United States Code, and while so
11 serving away from home and the member's regular
12 place of business, a member may be allowed travel
13 expenses, as authorized by the Chairperson of the
14 Small Business Health Board.

15 “(7) DISCLOSURE.—The Comptroller General
16 shall establish a system for the public disclosure, by
17 members of the Small Business Health Board, of fi-
18 nancial and other potential conflicts of interest.

19 “(8) MEETINGS.—The Small Business Health
20 Board shall meet at the call of the Chairperson.
21 Each such meeting shall be open to the public.

22 “(9) DUTIES.—The Small Business Health
23 Board shall—

1 “(A) provide general oversight of the pro-
2 gram under this title and make recommenda-
3 tions to the Administrator;

4 “(B) monitor and make recommendations
5 to the Administrator on the benefit require-
6 ments for national plans in this title;

7 “(C) make recommendations concerning
8 information that the Administrator, health
9 plans, and navigators should distribute to em-
10 ployers and employees participating in the pro-
11 gram under this title; and

12 “(D) monitor and make recommendations
13 to the Administrator on adverse selection within
14 the program under this title and between the
15 coverage provided under the program and the
16 State-regulated health insurance market.

17 “(10) APPROVAL OF RECOMMENDATIONS.—A
18 recommendation shall require approval by not less
19 than two-thirds of the members of the Board.

20 “(11) PUBLIC NOTICE AND COMMENT ON REC-
21 COMMENDATIONS.—The Administrator shall—

22 “(A) publish recommendations by the
23 Small Business Health Board in the Federal
24 Register;

1 “(B) solicit written comments concerning
2 such recommendations; and

3 “(C) provide an opportunity for the pres-
4 entation of oral comments concerning such rec-
5 ommendations at a public meeting.

6 **“SEC. 3003. NAVIGATORS.**

7 “(a) IN GENERAL.—The Administrator shall enter
8 into agreements with private and public entities, beginning
9 a reasonable period prior to the beginning of the first cal-
10 endar year in which health insurance coverage is offered
11 under this title, under which such entities will serve as
12 navigators.

13 “(b) ELIGIBILITY.—To be eligible to enter into an
14 agreement under subsection (a), an entity shall dem-
15 onstrate to the Administrator that the entity has existing
16 relationships with, or could readily establish relationships
17 with, employers and employees, and self-employed individ-
18 uals, likely to be eligible to participate in the program
19 under this title. Such entities may include trade, industry
20 and professional associations, chambers of commerce,
21 unions, small business development centers, and other en-
22 tities that the Administrator determines to be capable of
23 carrying out the duties described in subsection (c).

24 “(c) DUTIES.—An entity that serves as a navigator
25 under an agreement under subsection (a) shall—

1 “(1) coordinate with the Administrator on pub-
2 lic education activities to raise awareness of the pro-
3 gram under this title;

4 “(2) distribute information developed by the
5 Administrator on the open enrollment process, pri-
6 vate health plans available through the program
7 under this title, and standardized comparative infor-
8 mation about the health insurance coverage under
9 the program;

10 “(3) distribute information about the avail-
11 ability of the tax credit under section 36 of the In-
12 ternal Revenue Code of 1986 as added by the Small
13 Business Health Options Program Act of 2008;

14 “(4) assist employers and employees in enroll-
15 ing in the program under this title; and

16 “(5) respond to questions about the program
17 under this title and participating plans.

18 “(d) SUPPLEMENTAL MATERIALS.—In addition to
19 information developed by the Administrator under sub-
20 section (c)(2), a navigator may develop and distribute
21 other information that is related to the health insurance
22 program established under this title, subject to review and
23 approval by the Administrator and filing in each State in
24 which the navigator operates.

25 “(e) STANDARDS.—

1 “(1) IN GENERAL.—The Administrator shall es-
2 tablish standards for navigators under this section,
3 including provisions to avoid conflicts of interest.
4 Under such standards, a navigator may not—

5 “(A) be a health insurance issuer; or

6 “(B) receive any consideration directly or
7 indirectly from any health insurance issuer in
8 connection with the participation of any em-
9 ployer in the program under this title or the en-
10 rollment of any eligible employee in health in-
11 surance coverage under this title.

12 “(2) FAIR AND IMPARTIAL INFORMATION AND
13 SERVICES.—The Administrator shall consult with
14 the Small Business Health Board concerning the
15 standards necessary to ensure that a navigator will
16 provide fair and impartial information and services.
17 An agreement between the Administrator and a nav-
18 igator may include specific provisions with respect to
19 such navigator to ensure that such navigator will
20 provide fair and impartial information and services.
21 If a navigator, or entity seeking to become a navi-
22 gator, is a party to any arrangement with any health
23 insurance issuer to receive compensation related to
24 other health care programs not covered under this
25 title, the entity shall disclose the terms of such com-

1 pensation arrangements to the Administrator, and
2 the Administrator shall take such information into
3 account in determining the appropriate standards
4 and agreement terms for such navigator.

5 **“SEC. 3004. CONTRACTS WITH HEALTH INSURANCE**
6 **ISSUERS.**

7 “(a) IN GENERAL.—The Administrator may enter
8 into contracts with qualified health insurance issuers,
9 without regard to section 5 of title 41, United States Code,
10 or other statutes requiring competitive bidding, to provide
11 health benefits plans to employees of participating employ-
12 ers and self-employed individuals under this title. Each
13 contract shall be for a uniform term of at least 1 year,
14 but may be made automatically renewable from term to
15 term in the absence of notice of termination by either
16 party. In entering into such contracts, the Administrator
17 shall ensure that health benefits coverage is provided for
18 an individual only, two adults in a household, one adult
19 and one or more children, and a family.

20 “(b) ELIGIBILITY.—A health insurance issuer shall
21 be eligible to enter into a contract under subsection (a)
22 if such issuer—

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

1 “(2) meets such other reasonable requirements
2 as determined appropriate by the Administrator,
3 after an opportunity for public comment and publi-
4 cation in the Federal Register.

5 “(c) COST-SHARING AND NETWORKS.—The Adminis-
6 trator shall ensure that health benefits plans with a range
7 of cost-sharing and network arrangements are available
8 under this title.

9 “(d) REVOCATION.—Approval of a health benefits
10 plan participating in the program under this title may be
11 withdrawn or revoked by the Administrator only after no-
12 tice to the health insurance issuer involved and an oppor-
13 tunity for a hearing without regard to subchapter II of
14 chapter 5 and chapter 7 of title 5, United States Code.

15 “(e) CONVERSION.—

16 “(1) IN GENERAL.—Except as provided in para-
17 graph (2), a contract may not be made or a plan ap-
18 proved under this section if the health insurance
19 issuer under such contract or plan does not provide
20 to each enrollee whose coverage under the plan is
21 terminated, including a termination due to dis-
22 continuance of the contract or plan, the option to
23 have issued to that individual a nongroup policy
24 without evidence of insurability. A health insurance
25 issuer shall provide a notice of such option to indi-

1 individuals who enroll in the plan. An enrollee who exer-
2 cises such conversion option shall pay the full peri-
3 odic charges for the nongroup policy.

4 “(2) EXCEPTIONS.—A health insurance issuer
5 shall not be required to offer a nongroup policy
6 under paragraph (1) if the termination under the
7 plan occurred because—

8 “(A) the enrollee failed to pay any required
9 monthly premiums under the plan;

10 “(B) the enrollee performed an act or
11 practice that constitutes fraud in connection
12 with the coverage under the plan;

13 “(C) the enrollee made an intentional mis-
14 representation of a material fact under the
15 terms of coverage of the plan; or

16 “(D) the terminated coverage under the
17 plan was replaced by similar coverage within 31
18 days after the date of termination.

19 “(f) PAYMENT OF PREMIUMS.—

20 “(1) IN GENERAL.—Employers shall collect pre-
21 mium payments from their employees through pay-
22 roll deductions and shall forward such payments and
23 the contribution of the employer (if any) to the Ad-
24 ministrator. The Administrator shall develop proce-
25 dures through which such payments shall be received

1 and forwarded to the health insurance issuer in-
2 volved.

3 “(2) FAILURE TO PAY.—

4 “(A) IN GENERAL.—Failure to pay pre-
5 miums shall be treated as a debt owed to the
6 United States in the same manner as the fail-
7 ure to repay a loan made to an individual under
8 the Higher Education Act of 1965 is treated as
9 such a debt.

10 “(B) PROCEDURES.—The Administrator
11 shall establish procedures—

12 “(i) for the termination of employers
13 that fail, for a two consecutive month pe-
14 riod (or such other time period as deter-
15 mined appropriate by the Administrator),
16 to make premium payments in a timely
17 manner; and

18 “(ii) for recovering the cost of unpaid
19 and uncollected premiums through an ad-
20 justment in the rates charged for the sub-
21 sequent year in accordance with section
22 3007(b)(1)(C).

23 **“SEC. 3005. EMPLOYER PARTICIPATION.**

24 “(a) PARTICIPATION PROCEDURE.—The Adminis-
25 trator shall develop a procedure for employers and self-

1 employed individuals to participate in the program under
2 this title, including procedures relating to the offering of
3 health benefits plans to employees and the payment of pre-
4 miums for health insurance coverage under this title. For
5 the purpose of premium payments, a self-employed indi-
6 vidual shall be considered an employer that is making a
7 100 percent contribution toward the premium amount.

8 “(b) ENROLLMENT AND OFFERING OF OTHER COV-
9 ERAGE.—

10 “(1) ENROLLMENT.—A participating employer
11 shall ensure that each eligible employee has an op-
12 portunity to enroll in a plan of the employer’s choice
13 or a plan of the employee’s choice in accordance with
14 section 3007(d)(7).

15 “(2) PROHIBITION ON OFFERING OTHER COM-
16 PREHENSIVE HEALTH BENEFIT COVERAGE.—A par-
17 ticipating employer may not offer a health insurance
18 plan providing comprehensive health benefit coverage
19 to employees other than a health benefits plan of-
20 fered under this title.

21 “(3) PROHIBITION ON COERCION.—An em-
22 ployer shall not pressure, coerce, or offer induce-
23 ments to an employee to elect not to enroll in cov-
24 erage under the program under this title or to select
25 a particular health benefits plan.

1 “(4) OFFER OF SUPPLEMENTAL COVERAGE OP-
2 TIONS.—

3 “(A) IN GENERAL.—A participating em-
4 ployer may offer supplementary coverage op-
5 tions to employees.

6 “(B) DEFINITION.—In subparagraph (A),
7 the term ‘supplementary coverage’ means bene-
8 fits described as ‘excepted benefits’ under sec-
9 tion 2791(c).

10 “(c) REGULATORY FLEXIBILITY.—In developing the
11 procedure under subsection (a), the Administrator shall
12 comply with the requirements specified under the Regu-
13 latory Flexibility Act under chapter 6 of title 5, United
14 States Code, consider the economic impacts that the regu-
15 lation will have on small businesses, and consider regu-
16 latory alternatives that would mitigate such impact. The
17 Administrator shall publish and publicly disseminate a
18 small business compliance guide, pursuant to section 212
19 of the Small Business Regulatory Enforcement Fairness
20 Act, that explains the compliance requirements for em-
21 ployer participation. Such compliance guide shall be pub-
22 lished not later than the date of the publication of the
23 final rule under this title, or the effective date of such
24 rules, whichever is later.

1 “(d) RULE OF CONSTRUCTION.—Except as provided
2 in section 3004(f), nothing in this title shall be construed
3 to require that an employer make premium contributions
4 on behalf of employees.

5 **“SEC. 3006. ELIGIBILITY AND ENROLLMENT.**

6 “(a) IN GENERAL.—An individual shall be eligible to
7 enroll in health insurance coverage under this title for cov-
8 erage beginning in 2011 if such individual is an employee
9 of a participating employer described in section
10 3001(a)(4) or is a self-employed individual as defined in
11 section 401(c)(1)(B) of the Internal Revenue Code of
12 1986 and meets the definition of a participating employer
13 in section 3001(a)(8). An employer may allow employees
14 who average fewer than 35 hours per week to enroll.

15 “(b) LIMITATION.—A health insurance issuer may
16 not refuse to provide coverage to any eligible individual
17 under subsection (a) who selects a health benefits plan of-
18 fered by such issuer under this title.

19 “(c) TYPE OF ENROLLMENT.—An eligible individual
20 may enroll as an individual or as an adult with one or
21 more children regardless of whether another adult is
22 present in the enrollee’s household or family.

23 “(d) OPEN ENROLLMENT.—

24 “(1) IN GENERAL.—The Administrator shall es-
25 tablish an annual open enrollment period during

1 which an employer may elect to become a partici-
2 pating employer and an employee may enroll in a
3 health benefits plan under this title for the following
4 calendar year.

5 “(2) OPEN ENROLLMENT PERIOD.—For pur-
6 poses of this title, the term ‘open enrollment period’
7 means, with respect to calendar year 2011 and each
8 succeeding calendar year, the period beginning on
9 October 1, 2010, and ending December 1, 2010, and
10 each succeeding period beginning October 1 and
11 ending December 1. Coverage in a health benefits
12 plan selected during such an open enrollment period
13 shall begin on January 1 of the calendar year fol-
14 lowing the selection.

15 “(3) NEWLY ELIGIBLE EMPLOYERS AND EM-
16 PLOYEES.—Notwithstanding the open enrollment pe-
17 riod provided for under paragraph (2), the Adminis-
18 trator shall establish an enrollment process to enable
19 a newly eligible employer or an employer with an ex-
20 isting health benefits policy whose term is ending to
21 become a participating employer and for an em-
22 ployee of such employer, or a new employee of a par-
23 ticipating employer, to enroll in a health benefits
24 plan under this title outside of an open enrollment
25 period. The Administrator may establish a process

1 for setting the renewal date for the participation of
2 an employer that initially becomes a participating
3 employer outside of the open enrollment period to
4 coincide with a subsequent open enrollment period.

5 “(4) LIMITATION OF CHANGING ENROLL-
6 MENT.—An employer or employee (as the case may
7 be) may elect to change the health benefits plan that
8 the employee is enrolled in only during an open en-
9 rollment period.

10 “(5) EFFECTIVENESS OF ELECTION AND
11 CHANGE OF ELECTION.—An election to change a
12 health benefits plan that is made during the open
13 enrollment period under paragraph (2) shall take ef-
14 fect as of the first day of the following calendar
15 year.

16 “(6) CONTINUATION OF ENROLLMENT.—An
17 employee who has enrolled in a health benefits plan
18 under this title is considered to have been continu-
19 ously enrolled in that health benefits plan until such
20 time as—

21 “(A) the employer or employee (as the case
22 may be) elects to change health benefits plans;
23 or

24 “(B) the health benefits plan is termi-
25 nated.

1 “(e) PROVIDING INFORMATION TO PROMOTE IN-
2 FORMED CHOICE.—The Administrator shall compile,
3 produce, and disseminate information to employers, em-
4 ployees, and navigators under section 3002(c)(8) to pro-
5 mote informed choice that shall be made available at least
6 30 days prior to the beginning of each open enrollment
7 period.

8 “(f) TERMINATION OF EMPLOYMENT.—An employee
9 may remain enrolled in a health plan under this title for
10 the remainder of the calendar year following the termi-
11 nation or separation of the employee from employment or
12 termination of the employer, if the employee pays 100 per-
13 cent of the monthly premium for the remainder of the year
14 involved.

15 “(g) RULE OF CONSTRUCTION.—Nothing in this title
16 shall be construed to prohibit a health insurance issuer
17 providing coverage through the program under this title
18 from using the services of a licensed agent or broker.

19 **“SEC. 3007. HEALTH COVERAGE AVAILABLE WITHIN THE**
20 **SMALL BUSINESS POOL.**

21 “(a) PREEXISTING CONDITION EXCLUSIONS.—

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

1 “(2) EXCLUSION PERIOD.—A preexisting condi-
2 tion exclusion under this subsection shall provide for
3 coverage of a preexisting condition to begin not later
4 than 6 months after the date on which the coverage
5 of the individual under a health benefits plan com-
6 mences, reduced by the aggregate of 1 day for each
7 day that the individual was covered under creditable
8 health insurance coverage (as defined for purposes
9 of section 2701(c)) immediately preceding the date
10 the individual submitted an application for coverage
11 under this title. This provision shall be applied not-
12 withstanding the applicable provision for the reduc-
13 tion of the exclusion period provided for in section
14 701(a)(3) of the Employee Retirement Income Secu-
15 rity Act of 1974 (29 U.S.C. 1181(a)(3)).

16 “(b) RATES AND PREMIUMS; STATE LAWS.—

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

20 “(A) shall be determined in accordance
21 with subsection (d);

22 “(B) may be annually adjusted; and

23 “(C) shall be adjusted to cover the admin-
24 istrative costs of the Administrator under this

1 title and the office established under section
2 3002.

3 “(2) BENEFIT MANDATE LAWS.—With respect
4 to a contract entered into under this title under
5 which a health insurance issuer will offer health ben-
6 efits plan coverage, State mandated benefit laws in
7 effect in the State in which the plan is offered shall
8 continue to apply, except in the case of a nationwide
9 plan.

10 “(3) LIMITATION.—Nothing in this subsection
11 shall be construed to preempt any State or local law
12 (including any State grievance, claims, and appeals
13 procedure laws, State provider mandate laws, and
14 State network adequacy laws) except those laws and
15 regulations described in subsection (b)(2), (d)(2)(B),
16 and (d)(5).

17 “(c) TERMINATION AND REENROLLMENT.—If an in-
18 dividual who is enrolled in a health benefits plan under
19 this title voluntarily terminates the enrollment, except in
20 the case of an individual who has lost or changes employ-
21 ment or whose employer is terminated for failure to pay
22 premiums, the individual shall not be eligible for reenroll-
23 ment until the first open enrollment period following the
24 expiration of 6 months after the date of such termination.

1 “(d) RATING RULES AND TRANSITIONAL APPLICA-
2 TION OF STATE LAW.—

3 “(1) YEARS 2011 AND 2012.—With respect to
4 calendar years 2011 and 2012 (open enrollment pe-
5 riod beginning October 1, 2010, and October 1,
6 2011), the following shall apply:

7 “(A) In the case of an employer that elects
8 to participate in the program under this title,
9 the State rating requirements applicable to em-
10 ployers purchasing health insurance coverage in
11 the small group market in the State in which
12 the employer is located shall apply with respect
13 to such coverage, except that premium rates for
14 such coverage shall not vary based on health-
15 status related factors.

16 “(B) State rating requirements shall apply
17 to health insurance coverage purchased in the
18 small group market in the State, except that a
19 State shall be prohibited from allowing pre-
20 mium rates to vary based on health-status re-
21 lated factors.

22 “(2) SUBSEQUENT YEARS.—

23 “(A) NAIC RECOMMENDATIONS.—

24 “(i) STUDY.—Beginning in 2009, the
25 Administrator shall contract with the Na-

1 tional Association of Insurance Commis-
2 sioners to conduct a study of the rating re-
3 quirements utilized in the program under
4 this title and the rating requirements that
5 apply to health insurance purchased in the
6 small group markets in the States, and to
7 develop recommendations concerning rat-
8 ing requirements. Such recommendations
9 shall be submitted to the appropriate com-
10 mittees of Congress during calendar year
11 2011.

12 “(ii) CONSULTATION.—In conducting
13 the study under clause (i), the National
14 Association of Insurance Commissioners
15 shall consult with key stakeholders (includ-
16 ing small businesses, self-employed individ-
17 uals, employees of small businesses, health
18 insurance issuers, health care providers,
19 and patient advocates).

20 “(iii) RECOMMENDATIONS.—During
21 calendar year 2011, the recommendations
22 of the National Association of Insurance
23 Commissioners shall be submitted to Con-
24 gress (in the form of a legislative pro-
25 posal), and shall concern—

1 “(I) rating requirements for
2 health insurance coverage under this
3 title for calendar year 2013 and sub-
4 sequent calendar years; and

5 “(II) a maximum permissible
6 variance between State rating require-
7 ments and the rating requirements for
8 coverage under this title that will
9 allow State flexibility without causing
10 significant adverse selection for health
11 insurance coverage under this title.

12 “(B) APPLICATION OF REQUIREMENTS.—
13 If, pursuant to this subsection, an Act is en-
14 acted to implement rating requirements pursu-
15 ant to the recommendations submitted under
16 subparagraph (A), or alternative rating require-
17 ments developed by Congress, such rating re-
18 quirements shall apply to the program under
19 this title beginning in calendar year 2013 (open
20 enrollment periods beginning October 1, 2012,
21 and thereafter).

22 “(3) FAILURE TO ENACT LEGISLATION.—If an
23 Act is not enacted as provided for in paragraph
24 (2)(B), the fallback rating rules under paragraph
25 (5) shall apply beginning in calendar year 2013

1 (open enrollment periods beginning October 1, 2012,
2 and thereafter).

3 “(4) EXPEDITED CONGRESSIONAL CONSIDER-
4 ATION.—

5 “(A) INTRODUCTION AND COMMITTEE
6 CONSIDERATION.—

7 “(i) INTRODUCTION.—A legislative
8 proposal submitted to Congress pursuant
9 to paragraph (2) shall be introduced in the
10 House of Representatives by the Speaker,
11 and in the Senate by the majority leader,
12 immediately upon receipt of the language
13 and shall be referred to the appropriate
14 committees of Congress. If the proposal is
15 not introduced in accordance with the pre-
16 ceding sentence, legislation may be intro-
17 duced in either House of Congress by any
18 member thereof.

19 “(ii) COMMITTEE CONSIDERATION.—
20 Legislation introduced in the House of
21 Representatives and the Senate under
22 clause (i) shall be referred to the appro-
23 priate committees of jurisdiction of the
24 House of Representatives and the Senate.
25 Not later than 45 calendar days after the

1 introduction of the legislation or February
2 15th, 2012, whichever is later, the com-
3 mittee of Congress to which the legislation
4 was referred shall report the legislation or
5 a committee amendment thereto. If the
6 committee has not reported such legislation
7 (or identical legislation) at the end of 45
8 calendar days after its introduction, or
9 February 15th, 2012, whichever is later,
10 such committee shall be deemed to be dis-
11 charged from further consideration of such
12 legislation and such legislation shall be
13 placed on the appropriate calendar of the
14 House involved.

15 “(B) EXPEDITED PROCEDURE.—

16 “(i) CONSIDERATION.—Not later than
17 15 calendar days after the date on which
18 a committee has been or could have been
19 discharged from consideration of legislation
20 under this paragraph, the Speaker of the
21 House of Representatives, or the Speaker’s
22 designee, or the majority leader of the Sen-
23 ate, or the leader’s designee, shall move to
24 proceed to the consideration of the com-
25 mittee amendment to the legislation, and if

1 there is no such amendment, to the legisla-
2 tion. It shall also be in order for any mem-
3 ber of the House of Representatives or the
4 Senate, respectively, to move to proceed to
5 the consideration of the legislation at any
6 time after the conclusion of such 15-day
7 period. All points of order against the leg-
8 islation (and against consideration of the
9 legislation) with the exception of points of
10 order under the Congressional Budget Act
11 of 1974 are waived. A motion to proceed to
12 the consideration of the legislation is high-
13 ly privileged in the House of Representa-
14 tives and is privileged in the Senate and is
15 not debatable. The motion is not subject to
16 amendment, to a motion to postpone con-
17 sideration of the legislation, or to a motion
18 to proceed to the consideration of other
19 business. A motion to reconsider the vote
20 by which the motion to proceed is agreed
21 to or not agreed to shall not be in order.
22 If the motion to proceed is agreed to, the
23 House of Representatives or the Senate, as
24 the case may be, shall immediately proceed
25 to consideration of the legislation in ac-

1 cordance with the Standing Rules of the
2 House of Representatives or the Senate, as
3 the case may be, without intervening mo-
4 tion, order, or other business, and the reso-
5 lution shall remain the unfinished business
6 of the House of Representatives or the
7 Senate, as the case may be, until disposed
8 of, except as provided in clause (iii).

9 “(ii) CONSIDERATION BY OTHER
10 HOUSE.—If, before the passage by one
11 House of the legislation that was intro-
12 duced in such House, such House receives
13 from the other House legislation as passed
14 by such other House—

15 “(I) the legislation of the other
16 House shall not be referred to a com-
17 mittee and shall immediately displace
18 the legislation that was introduced in
19 the House in receipt of the legislation
20 of the other House; and

21 “(II) the legislation of the other
22 House shall immediately be considered
23 by the receiving House under the
24 same procedures applicable to legisla-

1 tion reported by or discharged from a
2 committee under this paragraph.

3 “Upon disposition of legislation that
4 is received by one House from the other
5 House, it shall no longer be in order to
6 consider the legislation that was introduced
7 in the receiving House.

8 “(iii) SENATE VOTE REQUIREMENT.—
9 Legislation under this paragraph shall only
10 be approved in the Senate if affirmed by
11 the votes of 3/5 of the Senators duly cho-
12 sen and sworn. If legislation in the Senate
13 has not reached final passage within 10
14 days after the motion to proceed is agreed
15 to (excluding periods in which the Senate
16 is in recess) it shall be in order for the ma-
17 jority leader to file a cloture petition on
18 the legislation or amendments thereto, in
19 accordance with rule XXII of the Standing
20 Rules of the Senate. If such a cloture mo-
21 tion on the legislation fails, is shall be in
22 order for the majority leader to proceed to
23 other business and the legislation shall be
24 returned to or placed on the Senate cal-
25 endar.

1 “(iv) CONSIDERATION IN CON-
2 FERENCE.—Immediately upon a final pas-
3 sage of the legislation that results in a dis-
4 agreement between the two Houses of Con-
5 gress with respect to the legislation, con-
6 ferees shall be appointed and a conference
7 convened. Not later than 15 days after the
8 date on which conferees are appointed (ex-
9 cluding periods in which one or both
10 Houses are in recess), the conferees shall
11 file a report with the House of Representa-
12 tives and the Senate resolving the dif-
13 ferences between the Houses on the legisla-
14 tion. Notwithstanding any other rule of the
15 House of Representatives or the Senate, it
16 shall be in order to immediately consider a
17 report of a committee of conference on the
18 legislation filed in accordance with this
19 subclause. Debate in the House of Rep-
20 resentatives and the Senate on the con-
21 ference report shall be limited to 10 hours,
22 equally divided and controlled by the
23 Speaker of the House of Representatives
24 and the minority leader of the House of
25 Representatives or their designees and the

1 majority and minority leaders of the Sen-
2 ate or their designees. A vote on final pas-
3 sage of the conference report shall occur
4 immediately at the conclusion or yielding
5 back of all time for debate on the con-
6 ference report. The conference report shall
7 be approved in the Senate only if affirmed
8 by the votes of 3/5 of the Senators duly
9 chosen and sworn.

10 “(C) RULES OF THE SENATE AND HOUSE
11 OF REPRESENTATIVES.—This paragraph is en-
12 acted by Congress—

13 “(i) as an exercise of the rulemaking
14 power of the Senate and House of Rep-
15 resentatives, respectively, and is deemed to
16 be part of the rules of each House, respec-
17 tively, but applicable only with respect to
18 the procedure to be followed in that House
19 in the case of legislation under this para-
20 graph, and it supersedes other rules only
21 to the extent that it is inconsistent with
22 such rules; and

23 “(ii) with full recognition of the con-
24 stitutional right of either House to change
25 the rules (so far as they relate to the pro-

1 cedure of that House) at any time, in the
2 same manner, and to the same extent as in
3 the case of any other rule of that House.

4 “(5) FALLBACK RATING RULES.—For purposes
5 of paragraph (3), the fallback rating rules are as fol-
6 lows:

7 “(A) PROGRAM.—

8 “(i) RATING RULES.—A health insur-
9 ance issuer that enters into a contract
10 under the program under this title shall
11 determine the amount of premiums to as-
12 sess for coverage under a health benefits
13 plan based on a community rate that may
14 be annually adjusted only—

15 “(I) based on the age of covered
16 individuals (subject to clause (iii));

17 “(II) based on the geographic
18 area involved if the adjustment is
19 based on geographical divisions that
20 are not smaller than a metropolitan
21 statistical area and the issuer provides
22 evidence of geographic variation in
23 cost of services;

24 “(III) based on industry (subject
25 to clause (iv));

1 “(IV) based on tobacco use; and

2 “(V) based on whether such cov-
3 erage is for an individual, 2 adults in
4 a household, 1 adult and 1 or more
5 children, or a family.

6 “(ii) LIMITATION.—Premium rates
7 charged for coverage under the program
8 under this title shall not vary based on
9 health-status related factors, gender, class
10 of business, or claims experience or any
11 other factor not described in clause (i).

12 “(iii) AGE ADJUSTMENTS.—

13 “(I) IN GENERAL.—With respect
14 to clause (i)(I), in making adjust-
15 ments based on age, the Adminis-
16 trator shall establish not more than 5
17 age brackets to be used by a health
18 insurance issuer in establishing rates
19 for individuals under the age of 65.
20 The rates for any age bracket shall
21 not exceed 300 percent of the rate for
22 the lowest age bracket. Age-related
23 premiums may not vary within age
24 brackets.

1 “(II) AGES 65 AND OLDER.—

2 With respect to clause (i)(I), a health
3 insurance issuer may develop separate
4 rates for covered individuals who are
5 65 years of age or older for whom the
6 primary payor for health benefits cov-
7 erage is the medicare program under
8 title XVIII of the Social Security Act,
9 for the coverage of health benefits
10 that are not otherwise covered under
11 medicare.

12 “(iv) INDUSTRY ADJUSTMENT.—With
13 respect to clause (i)(III), in making adjust-
14 ments based on industry, the rates for any
15 industry shall not exceed 115 percent of
16 the rate for the lowest industry and shall
17 be based on evidence of industry variation
18 in cost of services.

19 “(B) STATE RATING RULES.—State rating
20 requirements shall apply to health insurance
21 coverage purchased in the small group market,
22 except that a State shall not permit premium
23 rates to vary based on health-status related fac-
24 tors.

1 “(6) STATE WITH LESS PREMIUM VARIATION.—
2 Effective beginning in calendar year 2013, in the
3 case of a State that provides a rating variance with
4 respect to age that is less than the Federal limit es-
5 tablished under paragraph (2)(B) or (3) or that pro-
6 vides for some form of community rating, or that
7 provides a rating variance with respect to industry
8 that is less than the Federal limit established under
9 paragraph (2)(B) or (3), or that provides a rating
10 variance with respect to the geographic area involved
11 that is less than the Federal limit established in
12 paragraph (2)(B) or (3), premium rates charged for
13 health insurance coverage under this title in such
14 State with respect to such factor shall reflect the
15 rating requirements of such State.

16 “(7) EMPLOYEE CHOICE.—

17 “(A) CALENDAR YEARS 2011 AND 2012.—
18 With respect to calendar years 2011 and 2012
19 (open enrollment periods beginning October 1,
20 2010, and October 1, 2011), in the case of a
21 State that applies community rating or adjusted
22 community rating where any age bracket does
23 not exceed 300 percent of the lowest age brack-
24 et, employees of an employer located in that

1 State may elect to enroll in any health plan of-
2 fered under this title.

3 “(B) SUBSEQUENT YEARS.—Beginning in
4 calendar year 2013 (open enrollment periods
5 beginning October 1, 2012, and thereafter), em-
6 ployees of an employer that participates in the
7 program under this title may elect to enroll in
8 any health plan offered under this title.

9 “(C) EXCEPTION.—In any State or year in
10 which an employee is not able to select a health
11 plan as provided for in subparagraph (A) or
12 (B), the employer shall select the health plan or
13 plans that shall be made available to the em-
14 ployees of such employer.

15 “(8) STATE APPROVAL OF RATES.—State laws
16 requiring the approval of rates with respect to health
17 insurance shall continue to apply to health insurance
18 coverage under this title in such State unless the
19 State fails to enforce the application of rates that
20 would otherwise apply to health insurance issuers
21 under the program under this title.

22 “(e) BENEFITS.—

23 “(1) STATEMENT OF BENEFITS.—Each con-
24 tract under this title shall contain a detailed state-
25 ment of benefits offered and shall include informa-

1 tion concerning such maximums, limitations, exclu-
2 sions, and other definitions of benefits as the Ad-
3 ministrators considers necessary or reasonable.

4 “(2) NATIONWIDE PLANS.—

5 “(A) IN GENERAL.—In the case of con-
6 tracts with health insurance issuers that offer a
7 health benefit plan on a nationwide basis, in the
8 first year after the date of enactment of this
9 title, the benefit package shall include benefits
10 established by the Administrator.

11 “(B) PROCESS FOR ESTABLISHING BENE-
12 FITS FOR NATIONWIDE PLANS.—The benefits
13 provide for under subparagraph (A) shall be de-
14 termined as follows:

15 “(i) Not later than 30 days after the
16 date of enactment of this title, the Sec-
17 retary shall enter into a contract with the
18 Institute of Medicine to develop a min-
19 imum set of benefits to be offered by na-
20 tionwide plans.

21 “(ii) In developing such minimum set
22 of benefits, the Institute of Medicine shall
23 convene public forums to allow input from
24 key stakeholders (including small busi-
25 nesses, self-employed individuals, employ-

1 ees of small businesses, health insurance
2 issuers, insurance regulators, health care
3 providers, and patient advocates) and shall
4 consult with the Small Business Health
5 Board.

6 “(iii) The Institute of Medicine shall
7 consider—

8 “(I) the clinical appropriateness
9 and effectiveness of the benefits cov-
10 ered;

11 “(II) the affordability of the ben-
12 efits covered;

13 “(III) the financial protection of
14 enrollees against high health care ex-
15 penses;

16 “(IV) access to necessary health
17 care services; and

18 “(V) benefits similar to those
19 available in the small group market
20 on the date of enactment of this title.

21 “(iv) The benefits package shall not
22 be discriminatory or be likely to promote
23 or induce adverse selection.

1 “(v) The Administrator shall publish
2 the benefits recommended by the Institute
3 of Medicine for public comment.

4 “(vi) Based on the comments received,
5 the Administrator may make changes only
6 to the extent that the recommendation
7 from the Institute of Medicine is not con-
8 sistent with the criteria contained in clause
9 (iii) or there is a compelling need for the
10 changes to ensure the effective functioning
11 of the program.

12 “(C) CHANGES TO BENEFITS.—

13 “(i) IN GENERAL.—By a vote of a
14 two-thirds majority, the Small Business
15 Health Board may recommend to the Ad-
16 ministrator changes to the benefit package
17 for nationwide plans under this paragraph
18 for years subsequent to the first year in
19 which such benefits are in effect.

20 “(ii) REDUCTION IN BENEFITS.—The
21 Administrator may reduce benefits that
22 were previously covered under this para-
23 graph only if—

1 “(I) two-thirds of the Small
2 Business Health Board recommend
3 such change; or

4 “(II) there is a compelling need
5 for the change to prevent a substan-
6 tial reduction in participation in the
7 program under this title.

8 “(f) ADDITIONAL PREMIUM FOR DELAYED ENROLL-
9 MENT.—

10 “(1) IN GENERAL.—A self-employed individual
11 who is eligible to participate in the program under
12 this title, who does not reside in a State where a
13 self-employed individual is eligible for coverage in
14 the small group market, and who does not elect to
15 enroll in coverage under such program in the first
16 year in which the self-employed individual is eligible
17 to so enroll, shall be subject to an additional pre-
18 mium for delayed enrollment.

19 “(2) AMOUNT.—The Administrator shall estab-
20 lish the amount of the additional premium under
21 paragraph (1), which shall be the amount deter-
22 mined by the Administrator to be actuarially appro-
23 priate, to encourage enrollment, and to reduce ad-
24 verse selection. The amount of the additional pre-

1 mium shall be calculated by the Administrator based
2 on the number of years specified in paragraph (4).

3 “(3) PAYMENT.—A self-employed individual
4 shall pay the additional premium under this sub-
5 section, if any, for a period of time equal to the
6 number of years specified in paragraph (4). After
7 the expiration of such period the additional premium
8 for delayed enrollment shall be terminated.

9 “(4) YEARS.—The number of years specified in
10 this paragraph is the number of years that the self-
11 employed individual involved was eligible to partici-
12 pate in the program under this title but did not en-
13 roll in coverage under such program and did not
14 otherwise have creditable coverage (as defined for
15 purposes of section 2701(c)).

16 “(g) STATE ENFORCEMENT.—

17 “(1) STATE AUTHORITY.—With respect to the
18 enforcement of provisions in this title that supersede
19 State law (as described in paragraph (2)), a State
20 may require that health insurance issuers that issue,
21 sell, renew, or offer health insurance coverage in the
22 State in the small group market or through the pro-
23 gram under this title, comply with the requirements
24 of this title with respect to such issuers.

1 “(2) PROVISIONS DESCRIBED.—The provisions
2 described in this paragraph shall include the fol-
3 lowing:

4 “(A) Prohibitions on varying premium
5 rates based on health-status related factors
6 (subsections (d)(1)(A) and (B) of section
7 3007).

8 “(B) The implementation of rating re-
9 quirements that shall apply to the program
10 under this title beginning in calendar year 2013
11 (subsections (d)(2)(B) and (d)(3) of section
12 3007).

13 “(C) Benefit requirements for nationwide
14 plans available in the program under this title
15 (subsection (e)).

16 “(3) FAILURE TO IMPLEMENT OR ENFORCE
17 PROVISIONS.—In the case of a determination by the
18 Secretary that a State has failed to substantially en-
19 force a provision (or provisions) described in para-
20 graph (2) with respect to health insurance issuers in
21 the State, the Secretary shall enforce such provision
22 (or provisions).

23 “(4) SECRETARIAL ENFORCEMENT AUTHOR-
24 ITY.—The Secretary shall have the same authority
25 in relation to the enforcement of the provisions of

1 this title with respect to issuers of health insurance
2 coverage in a State as the Secretary has under sec-
3 tion 2722(b)(2) in relation to the enforcement of the
4 provisions of part A of title XXVII with respect to
5 issuers of health insurance coverage in the small
6 group market in the State.

7 “(h) STATE OPT OUT.—A State may prohibit small
8 employers and self-employed individuals in the State from
9 participating in the program under this title if the State—

10 “(1) defines its small group market to include
11 groups of one (so that self-employed individuals are
12 eligible for coverage in such market);

13 “(2) prohibits the use of health-status related
14 factors and other factors described in subsection
15 (d)(5)(A);

16 “(3) has in effect rating rules that—

17 “(A) in calendar years 2011 and 2012,
18 comply with subsection (d)(5)(A); and

19 “(B) in calendar year 2013 and thereafter,
20 comply with subsection (d)(2)(B) or (d)(3),
21 whichever is in effect for such calendar year;

22 except that such rules may impose limits on rating
23 variation in addition to those provided for in such
24 subsection;

1 “(4) maintains a State-wide purchasing pool
2 that provides purchasers in the small group market
3 a choice of health benefit plans, with comparative in-
4 formation provided concerning such plans and the
5 premiums charged for such plans made available
6 through the Internet; and

7 “(5) enacts a law to request an opt out under
8 this subsection.

9 **“SEC. 3008. ENCOURAGING PARTICIPATION BY HEALTH IN-**
10 **SURANCE ISSUERS THROUGH ADJUSTMENTS**
11 **FOR RISK.**

12 “(a) APPLICATION OF RISK CORRIDORS.—

13 “(1) IN GENERAL.—This section shall only
14 apply to health insurance issuers with respect to
15 health benefits plans offered under this Act during
16 any of calendar years 2011 through 2013.

17 “(2) NOTIFICATION OF COSTS UNDER THE
18 PLAN.—In the case of a health insurance issuer that
19 offers a health benefits plan under this title in any
20 of calendar years 2011 through 2013, the issuer
21 shall notify the Administrator, before such date in
22 the succeeding year as the Administrator specifies,
23 of the total amount of costs incurred in providing
24 benefits under the health benefits plan for the year

1 involved and the portion of such costs that is attrib-
2 utable to administrative expenses.

3 “(3) ALLOWABLE COSTS DEFINED.—For pur-
4 poses of this section, the term ‘allowable costs’
5 means, with respect to a health benefits plan offered
6 by a health insurance issuer under this title, for a
7 year, the total amount of costs described in para-
8 graph (2) for the plan and year, reduced by the por-
9 tion of such costs attributable to administrative ex-
10 penses incurred in providing the benefits described
11 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 health insurance issuer with re-
16 spect to the health benefits plan involved for a cal-
17 endar year are at least 97 percent, but do not exceed
18 103 percent, of the target amount for the plan and
19 year involved, there shall be no payment adjustment
20 under this 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 health insurance issuer with re-

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

10 “(B) COSTS ABOVE 108 PERCENT OF TAR-
11 GET AMOUNT.—If the allowable costs for the
12 health insurance issuer with respect to the
13 health benefits plan involved for the year are
14 greater than 108 percent of the target amount
15 for the plan and year, the Administrator shall
16 reimburse the issuer for such excess costs
17 through payment to the issuer in an amount
18 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 such allowable costs and 108 percent
23 of such target amount.

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

1 “(A) COSTS BETWEEN 92 AND 97 PERCENT
2 OF TARGET AMOUNT.—If the allowable costs for
3 the health insurance issuer with respect to the
4 health benefits plan involved for the year are
5 less than 97 percent, but greater than or equal
6 to 92 percent, of the target amount for the plan
7 and year, the issuer shall be required to pay
8 into a contingency reserve fund established and
9 maintained by the Administrator, an amount
10 equal to 75 percent of the difference between
11 97 percent of the target amount and such al-
12 lowable costs.

13 “(B) COSTS BELOW 92 PERCENT OF TAR-
14 GET AMOUNT.—If the allowable costs for the
15 health insurance issuer with respect to the
16 health benefits plan involved for the year are
17 less than 92 percent of the target amount for
18 the plan and year, the issuer shall be required
19 to pay into the contingency fund established
20 under subparagraph (A), an amount equal to
21 the sum of—

22 “(i) 3.75 percent of such target
23 amount; and

1 “(ii) 90 percent of the difference be-
2 tween 92 percent of such target amount
3 and such allowable costs.

4 “(4) TARGET AMOUNT DESCRIBED.—

5 “(A) IN GENERAL.—For purposes of this
6 subsection, the term ‘target amount’ means,
7 with respect to a health benefits plan offered by
8 an issuer under this title in any of calendar
9 years 2011 through 2013, an amount equal
10 to—

11 “(i) the total of the monthly pre-
12 miums estimated by the health insurance
13 issuer and accepted by the Administrator
14 to be paid for enrollees in the plan under
15 this title for the calendar year involved; re-
16 duced by

17 “(ii) the amount of administrative ex-
18 penses that the issuer estimates, and the
19 Administrator accepts, will be incurred by
20 the issuer with respect to the plan for such
21 calendar year.

22 “(B) SUBMISSION OF TARGET AMOUNT.—
23 Not later than December 31, 2010, and each
24 December 31 thereafter through calendar year
25 2012, an issuer shall submit to the Adminis-

1 trator a description of the target amount for
2 such issuer with respect to health benefits plans
3 provided by the issuer under this title.

4 “(c) DISCLOSURE OF INFORMATION.—

5 “(1) IN GENERAL.—Each contract under this
6 title shall provide—

7 “(A) that a health insurance issuer offer-
8 ing a health benefits plan under this title shall
9 provide the Administrator with such informa-
10 tion as the Administrator determines is nec-
11 essary to carry out this subsection including the
12 notification of costs under subsection (a)(2) and
13 the target amount under subsection (b)(4)(B);
14 and

15 “(B) that the Administrator has the right
16 to inspect and audit any books and records of
17 the issuer that pertain to the information re-
18 garding costs provided to the Administrator
19 under such subsections.

20 “(2) RESTRICTION ON USE OF INFORMATION.—

21 Information disclosed or obtained pursuant to the
22 provisions of this subsection may be used by the of-
23 fice designated under section 3002(a) and its em-
24 ployees and contractors only for the purposes of, and
25 to the extent necessary in, carrying out this section.

1 **“SEC. 3009. ADMINISTRATION THROUGH REGIONAL OR**
2 **OTHER ADMINISTRATIVE ENTITIES.**

3 “(a) IN GENERAL.—In order to provide for the ad-
4 ministration of the benefits under this title with maximum
5 efficiency and convenience for participating employers and
6 health care providers and other individuals and entities
7 providing services to such employers, the Administrator—

8 “(1) shall enter into contracts with eligible enti-
9 ties, to the extent appropriate, to perform, on a re-
10 gional or other basis, activities to receive, disburse,
11 and account for payments of premiums to partici-
12 pating employers by individuals, and for payments
13 by participating employers and employees to health
14 insurance issuers; and

15 “(2) may enter into contracts with eligible enti-
16 ties, to the extent appropriate, to perform, on a re-
17 gional or other basis, one or more of the following:

18 “(A) Collect and maintain all information
19 relating to individuals, families, and employers
20 participating in the program under this title.

21 “(B) Serve as a channel of communication
22 between health insurance issuers, participating
23 employers, and individuals relating to the ad-
24 ministration of this title.

25 “(C) Otherwise carry out such activities
26 for the administration of this title, in such

1 manner, as may be provided for in the contract
2 entered into under this section.

3 “(b) APPLICATION.—To be eligible to receive a con-
4 tract under subsection (a), an entity shall prepare and
5 submit to the Administrator an application at such time,
6 in such manner, and containing such information as the
7 Administration may require.

8 “(c) PROCESS.—

9 “(1) COMPETITIVE BIDDING.—All contracts
10 under this section shall be awarded through a com-
11 petitive bidding process on a bi-annual basis.

12 “(2) REQUIREMENT.—No contract shall be en-
13 tered into with any entity under this section unless
14 the Administrator finds that such entity will perform
15 its obligations under the contract efficiently and ef-
16 fectively and will meet such requirements as to fi-
17 nancial responsibility, legal authority, and other
18 matters as the Administrator finds pertinent.

19 “(3) PUBLICATION OF STANDARDS AND CRI-
20 TERIA.—If the Administrator enters into contracts
21 under subsection (a), the Administrator shall publish
22 in the Federal Register standards and criteria for
23 the efficient and effective performance of contract
24 obligations under this section, and opportunity shall
25 be provided for public comment prior to implementa-

1 tion. In establishing such standards and criteria, the
2 Administrator shall provide for a system to measure
3 an entity's performance of responsibilities.

4 “(4) TERM.—Each contract under this section
5 shall be for a term of at least 2 years, and may be
6 made automatically renewable from term to term in
7 the absence of notice by either party of intention to
8 terminate at the end of the current term, except that
9 the Administrator may terminate any such contract
10 at any time (after such reasonable notice and oppor-
11 tunity for hearing to the entity involved as the Ad-
12 ministrator may provide in regulations) if the Ad-
13 ministrator finds that the entity has failed substan-
14 tially to carry out the contract or is carrying out the
15 contract in a manner inconsistent with the efficient
16 and effective administration of the program estab-
17 lished by this title.

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

20 “(1) a description of the duties of the con-
21 tracting entity;

22 “(2) an assurance that the entity will furnish to
23 the Administrator such timely information and re-
24 ports as the Administrator determines appropriate;

1 “(3) an assurance that the entity will maintain
2 such records and afford such access thereto as the
3 Administrator finds necessary to assure the correct-
4 ness and verification of the information and reports
5 under paragraph (2) and otherwise to carry out the
6 purposes of this title;

7 “(4) an assurance that the entity shall comply
8 with such confidentiality and privacy protection
9 guidelines and procedures as the Administrator may
10 require;

11 “(5) an assurance that the entity does not have,
12 and will continue to avoid, any conflicts of interest
13 relative to any functions it will perform; and

14 “(6) such other terms and conditions not incon-
15 sistent with this section as the Administrator may
16 find necessary or appropriate.

17 **“SEC. 3010. PUBLIC EDUCATION CAMPAIGN AND REPORT.**

18 “(a) IN GENERAL.—In carrying out this title, the Ad-
19 ministrator shall develop and implement an educational
20 campaign with interagency participation (including at a
21 minimum the Small Business Administration, the Depart-
22 ment of Labor, and employees of the office established
23 under section 3002 who oversee the provision of informa-
24 tion through navigators) to provide information to employ-
25 ers and the general public concerning the health insurance

1 program developed under this title, including the contact
2 information relating to an individual or individuals who
3 will be available to resolve various types of problems with
4 health insurance coverage provided under this title.

5 “(b) PUBLIC EDUCATION CAMPAIGN.—There is au-
6 thorized to be appropriated to carry out this section, such
7 sums as may be necessary for each of fiscal years 2008
8 through 2010.

9 “(c) REPORTS TO CONGRESS.—Not later than 1 year
10 and 2 years after the implementation of the campaign
11 under subsection (a), the Administrator shall submit to
12 the appropriate committees of Congress a report that de-
13 scribes the activities of the Administrator under sub-
14 section (a), including a determination by the Adminis-
15 trator of the percentage of employers with knowledge of
16 the health benefits program under this title.

17 **“SEC. 3011. APPROPRIATIONS.**

18 “There are authorized to be appropriated to the Ad-
19 ministrator such sums as may be necessary in each fiscal
20 year for the development and administration of the pro-
21 gram under this title.

22 **“SEC. 3012. EFFECTIVE DATE.**

23 “This title shall take effect on the date of enactment
24 of this title.”.

1 **SEC. 3. AMENDMENT TO ERISA.**

2 Section 514(b)(2) of the Employee Retirement In-
3 come Security Act of 1974 (29 U.S.C. 1144(b)(2)) is
4 amended by adding at the end the following:

5 “(C) Notwithstanding subparagraph (A), the provi-
6 sions of subsections (d)(1)(B) and (g)(2)(A) of section
7 3007 of the Public Health Service Act (relating to the pro-
8 hibition on health-status related rating and the Federal
9 enforcement of such provisions) shall supercede any State
10 law that conflicts with such provisions.”.

11 **SEC. 4. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH**
12 **INSURANCE EXPENSES.**

13 (a) IN GENERAL.—Subpart D of part IV of sub-
14 chapter A of chapter 1 of the Internal Revenue Code of
15 1986 (relating to credits) is amended by inserting after
16 section 45N the following new section:

17 **“SEC. 45O. SMALL BUSINESS EMPLOYEE HEALTH INSUR-**
18 **ANCE CREDIT.**

19 “(a) DETERMINATION OF CREDIT.—In the case of a
20 qualified small employer, there shall be allowed as a credit
21 against the tax imposed by this chapter for the taxable
22 year an amount equal to the credit amount described in
23 subsection (b).

24 “(b) GENERAL CREDIT AMOUNT.—For purposes of
25 this section—

1 “(1) IN GENERAL.—The credit amount de-
2 scribed in this subsection is the product of—

3 “(A) the amount specified in paragraph
4 (2),

5 “(B) the employer size factor specified in
6 paragraph (3), and

7 “(C) the percentage of year factor specified
8 in paragraph (4).

9 “(2) APPLICABLE AMOUNT.—For purposes of
10 paragraph (1)—

11 “(A) IN GENERAL.—The applicable
12 amount is equal to—

13 “(i) \$1,000 for each employee of the
14 employer who receives self-only health in-
15 surance coverage through the employer,

16 “(ii) \$2,000 for each employee of the
17 employer who receives family health insur-
18 ance coverage through the employer, and

19 “(iii) \$1,500 for each employee of the
20 employer who receives health insurance
21 coverage for two adults or one adult and
22 one or more children through the employer.

23 “(B) BONUS FOR PAYMENT OF GREATER
24 PERCENTAGE OF PREMIUMS.—The applicable
25 amount otherwise specified in subparagraph (A)

1 shall be increased by \$200 in the case of sub-
 2 paragraph (A)(i), \$400 in the case of subpara-
 3 graph (A)(ii), and \$300 in the case of subpara-
 4 graph (A)(iii), for each additional 10 percent of
 5 the qualified employee health insurance ex-
 6 penses exceeding 60 percent which are paid by
 7 the qualified small employer.

8 “(3) EMPLOYER SIZE FACTOR.—For purposes
 9 of paragraph (1), the employer size factor is the per-
 10 centage determined in accordance with the following
 11 table:

“If the employer size is:	The percent- age is:
10 or fewer full-time employees	100%
More than 10 but not more than 20 full-time employees	80%
More than 20 but not more than 30 full-time employees	60%
More than 30 but not more than 40 full-time employees	40%
More than 40 but not more than 50 full-time employees	20%
More than 50 full-time employees	0%

12 “(4) PERCENTAGE OF YEAR FACTOR.—For pur-
 13 poses of paragraph (1), the percentage of year factor
 14 is equal to the ratio of—

15 “(A) the number of months during the tax-
 16 able year for which the employer paid or in-
 17 curred qualified employee health insurance ex-
 18 penses, and

19 “(B) 12.

1 “(c) DEFINITIONS AND SPECIAL RULES.—For pur-
2 poses of this section—

3 “(1) QUALIFIED SMALL EMPLOYER.—

4 “(A) IN GENERAL.—The term ‘qualified
5 small employer’ means any employer (as defined
6 in section 3001(a)(4) of the Public Health
7 Service Act) which—

8 “(i) either—

9 “(I) purchases health insurance
10 coverage for its employees in a small
11 group market in a State which meets
12 the requirements under subparagraph
13 (B), or

14 “(II) with respect to any taxable
15 year beginning after 2010, is a par-
16 ticipating employer (as defined in sec-
17 tion 3001(a)(8) of such Act) in the
18 program under title XXX of such Act,

19 “(ii) pays or incurs at least 60 per-
20 cent of the qualified employee health insur-
21 ance expenses of such employer or is self-
22 employed, and

23 “(iii) employed an average of 50 or
24 fewer full-time employees during the pre-
25 ceding taxable year or was a self-employed

1 individual with either not less than \$5,000
2 in net earnings or not less than \$15,000 in
3 gross earnings from self-employment in the
4 preceding taxable year.

5 “(B) STATE SMALL GROUP MARKET RE-
6 QUIREMENTS.—A State meets the requirements
7 of this subparagraph if—

8 “(i) during calendar years 2009 and
9 2010, the State—

10 “(I) defines its small group mar-
11 ket to include groups of one (so that
12 self-employed individuals are eligible
13 for coverage in such market),

14 “(II) prohibits the use of health-
15 status related factors and other fac-
16 tors described in section
17 3007(d)(5)(A) of such Act, and

18 “(III) has in effect rating rules
19 that comply with section
20 3007(d)(5)(A) of such Act (except
21 that such rules may impose limits on
22 rating variation in addition to those
23 provided for in such section),

24 “(ii) during calendar years 2011 and
25 2012, the State—

1 “(I) meets the requirements
2 under clause (i), and

3 “(II) maintains a State-wide pur-
4 chasing pool that provides purchasers
5 in the small group market a choice of
6 health benefit plans, with comparative
7 information provided concerning such
8 plans and the premiums charged for
9 such plans made available through the
10 Internet, and

11 “(iii) for calendar years after 2012,
12 the State—

13 “(I) meets the requirements
14 under clauses (i)(I), (i)(II), and
15 (ii)(II), and

16 “(II) has in effect rating rules
17 that comply with paragraph (2)(B) or
18 (3) of section 3007(d) of such Act,
19 whichever is in effect for such cal-
20 endar year (except that such rules
21 may impose limits on rating variation
22 in addition to those provided for in
23 such section).

24 “(2) QUALIFIED EMPLOYEE HEALTH INSUR-
25 ANCE EXPENSES.—

1 “(A) IN GENERAL.—The term ‘qualified
2 employee health insurance expenses’ means any
3 amount paid by an employer or an employee of
4 such employer for health insurance coverage
5 under such Act to the extent such amount is at-
6 tributable to coverage—

7 “(i) provided to any employee (as de-
8 fined in subsection 3001(a)(3) of such
9 Act), or

10 “(ii) for the employer, in the case of
11 a self-employed individual.

12 “(B) EXCEPTION FOR AMOUNTS PAID
13 UNDER SALARY REDUCTION ARRANGEMENTS.—
14 No amount paid or incurred for health insur-
15 ance coverage pursuant to a salary reduction
16 arrangement shall be taken into account under
17 subparagraph (A).

18 “(3) FULL-TIME EMPLOYEE.—The term ‘full-
19 time employee’ means, with respect to any period, an
20 employee (as defined in section 3001(a)(3) of such
21 Act) of an employer if the average number of hours
22 worked by such employee in the preceding taxable
23 year for such employer was at least 35 hours per
24 week.

25 “(d) INFLATION ADJUSTMENT.—

1 “(1) IN GENERAL.—For each taxable year after
2 2009, the dollar amounts specified in subsections
3 (b)(2)(A), (b)(2)(B), and (c)(1)(A)(iii) (after the ap-
4 plication of this paragraph) shall be the amounts in
5 effect in the preceding taxable year or, if greater,
6 the product of—

7 “(A) the corresponding dollar amount
8 specified in such subsection, and

9 “(B) the ratio of the index of wage infla-
10 tion (as determined by the Bureau of Labor
11 Statistics) for August of the preceding calendar
12 year to such index of wage inflation for August
13 of 2008.

14 “(2) ROUNDING.—If any amount determined
15 under paragraph (1) is not a multiple of \$100, such
16 amount shall be rounded to the next lowest multiple
17 of \$100.

18 “(e) APPLICATION OF CERTAIN RULES IN DETER-
19 MINATION OF EMPLOYER SIZE.—For purposes of this sec-
20 tion—

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 shall 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 preceding taxable
4 year, the determination of whether such employer
5 meets the requirements of this section shall be based
6 on the average number of full-time employees that it
7 is reasonably expected such employer will employ on
8 business days in the employer’s first full taxable
9 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 “(f) COORDINATION WITH ADVANCE PAYMENTS OF
14 CREDIT.—With respect to any taxable year, the amount
15 which would (but for this subsection) be allowed as a cred-
16 it to the taxpayer under subsection (a) shall be reduced
17 by the aggregate amount paid on behalf of such taxpayer
18 under section 7527A for months beginning in such taxable
19 year. If the amount determined under this subsection is
20 less than zero, the taxpayer shall owe additional tax in
21 such amount under this chapter.

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) **ADVANCE PAYMENTS OF CREDIT.**—Chapter 77
4 of the Internal Revenue Code of 1986 is amended by in-
5 serting after section 7527 the following new section:

6 **“SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
7 **INSURANCE COSTS FOR QUALIFIED SMALL**
8 **EMPLOYERS.**

9 “(a) **GENERAL RULE.**—Not later than December 31,
10 2008, the Secretary shall establish a program for making
11 monthly payments on behalf of qualified small employers
12 to the program established under title XXX of the Public
13 Health Service Act. The amount of the monthly payment
14 for a qualified small employer shall be one twelfth of the
15 amount of the credit for the tax year to which the qualified
16 small employer is entitled under section 36. If a monthly
17 payment is made by the Secretary for which the employer
18 is not entitled to a corresponding credit, the employer shall
19 owe additional tax in such amount under this chapter.

20 “(b) **QUALIFIED SMALL EMPLOYER.**—For purposes
21 of this section, the term ‘qualified small employer’ has the
22 meaning given such term in section 36(e)(1).”.

23 (c) **CONFORMING AMENDMENTS.**—

24 (1) The table of sections for subpart D of part
25 IV of subchapter A of chapter 1 of the Internal Rev-

1 enue Code of 1986 is amended by adding at the end
2 the following new items:

“Sec. 45O. Small business employee health insurance credit.”.

3 (2) The table of sections for chapter 77 of such
4 Code is amended by inserting after the item relating
5 to section 7527 the following new item:

“Sec. 7527A. Advance payment of credit for health insurance costs for qualified
small employers.”.

6 (d) DEDUCTIBILITY.—The payment of premiums by
7 a participating employer under this Act shall be consid-
8 ered to be an ordinary and necessary expense in carrying
9 on a trade or business for purposes of the Internal Rev-
10 enue Code of 1986 and shall be deductible.

11 (e) 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, 2008.

○