

110TH CONGRESS  
2D SESSION

# S. 2818

To amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to provide for enhanced health insurance marketplace pooling and relating market rating.

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## IN THE SENATE OF THE UNITED STATES

APRIL 3, 2008

Mr. ENZI (for himself, Mr. NELSON of Nebraska, and Mr. GREGG) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## A BILL

To amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to provide for enhanced health insurance marketplace pooling and relating market rating.

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 Plans Act of 2008”.

1                   **TITLE I—ENHANCED**  
 2                   **MARKETPLACE POOLS**

3 **SEC. 101. RULES GOVERNING ENHANCED MARKETPLACE**  
 4                   **POOLS.**

5           (a) IN GENERAL.—Subtitle B of title I of the Em-  
 6 ployee Retirement Income Security Act of 1974 is amend-  
 7 ed by adding after part 7 the following new part:

8                   **“PART 8—RULES GOVERNING ENHANCED**  
 9                   **MARKETPLACE POOLS**

10 **“SEC. 801. SMALL BUSINESS HEALTH PLANS.**

11           “(a) IN GENERAL.—For purposes of this part, the  
 12 term ‘small business health plan’ means a fully insured  
 13 group health plan whose sponsor is (or is deemed under  
 14 this part to be) described in subsection (b).

15           “(b) SPONSORSHIP.—The sponsor of a group health  
 16 plan is described in this subsection if such sponsor—

17                   “(1) is organized and maintained in good faith,  
 18 with a constitution and bylaws specifically stating its  
 19 purpose and providing for periodic meetings on at  
 20 least an annual basis, as a bona fide trade associa-  
 21 tion, a bona fide industry association (including a  
 22 rural electric cooperative association or a rural tele-  
 23 phone cooperative association), a bona fide profes-  
 24 sional association, or a bona fide chamber of com-  
 25 merce (or similar bona fide business association, in-

1 including a corporation or similar organization that  
2 operates on a cooperative basis (within the meaning  
3 of section 1381 of the Internal Revenue Code of  
4 1986)), for substantial purposes other than that of  
5 obtaining medical care;

6 “(2) is established as a permanent entity which  
7 receives the active support of its members and re-  
8 quires for membership payment on a periodic basis  
9 of dues or payments necessary to maintain eligibility  
10 for membership;

11 “(3) does not condition membership, such dues  
12 or payments, or coverage under the plan on the  
13 basis of health status-related factors with respect to  
14 the employees of its members (or affiliated mem-  
15 bers), or the dependents of such employees, and does  
16 not condition such dues or payments on the basis of  
17 group health plan participation; and

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

20 Any sponsor consisting of an association of entities which  
21 meet the requirements of paragraphs (1), (2), (3), and (4)  
22 shall be deemed to be a sponsor described in this sub-  
23 section.

1 **“SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZA-**  
2 **TIONS.**

3 “(a) IN GENERAL.—The Secretary, not later than 1  
4 year after the date of enactment of this part, shall promul-  
5 gate regulations that apply the rules and standards of this  
6 part, as necessary, to circumstances in which a pooling  
7 entity other (hereinafter ‘Alternative Market Pooling Or-  
8 ganizations’) is not made up principally of employers and  
9 their employees, or not a professional organization or such  
10 small business health plan entity identified in section 801.

11 “(b) ADAPTION OF STANDARDS.—In developing and  
12 promulgating regulations pursuant to subsection (a), the  
13 Secretary, in consultation with the Secretary of Health  
14 and Human Services, small business health plans, small  
15 and large employers, large and small insurance issuers,  
16 consumer representatives, and state insurance commis-  
17 sioners, shall—

18 “(1) adapt the standards of this part, to the  
19 maximum degree practicable, to assure balanced and  
20 comparable oversight standards for both small busi-  
21 ness health plans and alternative market pooling or-  
22 ganizations;

23 “(2) permit the participation as alternative  
24 market pooling organizations unions, churches and  
25 other faith-based organizations, or other organiza-  
26 tions composed of individuals and groups which may

1 have little or no association with employment, pro-  
2 vided however, that such alternative market pooling  
3 organizations meet, and continue meeting on an on-  
4 going basis, to satisfy standards, rules, and require-  
5 ments materially equivalent to those set forth in this  
6 part with respect to small business health plans;

7 “(3) conduct periodic verification of such com-  
8 pliance by alternative market pooling organizations,  
9 in consultation with the Secretary of Health and  
10 Human Services and the National Association of In-  
11 surance Commissioners, except that such periodic  
12 verification shall not materially impede market entry  
13 or participation as pooling entities comparable to  
14 that of small business health plans;

15 “(4) assure that consistent, clear, and regularly  
16 monitored standards are applied with respect to al-  
17 ternative market pooling organizations to avert ma-  
18 terial risk-selection within or among the composition  
19 of such organizations;

20 “(5) the expedited and deemed certification pro-  
21 cedures provided in section 805(d) shall not apply to  
22 alternative market pooling organizations until sooner  
23 of the promulgation of regulations under this sub-  
24 section or the expiration of one year following enact-  
25 ment of this Act; and



1       “(c) REQUIREMENTS FOR CONTINUED CERTIFI-  
2    CATION.—The applicable authority may provide by regula-  
3    tion for continued certification of small business health  
4    plans under this part. Such regulation shall provide for  
5    the revocation of a certification if the applicable authority  
6    finds that the small business health plan involved is failing  
7    to comply with the requirements of this part.

8       “(d) EXPEDITED AND DEEMED CERTIFICATION.—

9           “(1) IN GENERAL.—If the Secretary fails to act  
10    on an application for certification under this section  
11    within 90 days of receipt of such application, the ap-  
12    plying small business health plan shall be deemed  
13    certified until such time as the Secretary may deny  
14    for cause the application for certification.

15          “(2) CIVIL PENALTY.—The Secretary may as-  
16    sess a civil penalty against the board of trustees and  
17    plan sponsor (jointly and severally) of a small busi-  
18    ness health plan that is deemed certified under para-  
19    graph (1) of up to \$500,000 in the event the Sec-  
20    retary determines that the application for certifi-  
21    cation of such small business health plan was will-  
22    fully or with gross negligence incomplete or inac-  
23    curate.

1 **“SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND**  
 2 **BOARDS OF TRUSTEES.**

3 “(a) SPONSOR.—The requirements of this subsection  
 4 are met with respect to a small business health plan if  
 5 the sponsor has met (or is deemed under this part to have  
 6 met) the requirements of section 801(b) for a continuous  
 7 period of not less than 3 years ending with the date of  
 8 the application for certification under this part.

9 “(b) BOARD OF TRUSTEES.—The requirements of  
 10 this subsection are met with respect to a small business  
 11 health plan if the following requirements are met:

12 “(1) FISCAL CONTROL.—The plan is operated,  
 13 pursuant to a plan document, by a board of trustees  
 14 which pursuant to a trust agreement has complete  
 15 fiscal control over the plan and which is responsible  
 16 for all operations of the plan.

17 “(2) RULES OF OPERATION AND FINANCIAL  
 18 CONTROLS.—The board of trustees has in effect  
 19 rules of operation and financial controls, based on a  
 20 3-year plan of operation, adequate to carry out the  
 21 terms of the plan and to meet all requirements of  
 22 this title applicable to the plan.

23 “(3) RULES GOVERNING RELATIONSHIP TO  
 24 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
 25 TORS.—

26 “(A) BOARD MEMBERSHIP.—

1           “(i) IN GENERAL.—Except as pro-  
2           vided in clauses (ii) and (iii), the members  
3           of the board of trustees are individuals se-  
4           lected from individuals who are the owners,  
5           officers, directors, or employees of the par-  
6           ticipating employers or who are partners in  
7           the participating employers and actively  
8           participate in the business.

9           “(ii) LIMITATION.—

10           “(I) GENERAL RULE.—Except as  
11           provided in subclauses (II) and (III),  
12           no such member is an owner, officer,  
13           director, or employee of, or partner in,  
14           a contract administrator or other  
15           service provider to the plan.

16           “(II) LIMITED EXCEPTION FOR  
17           PROVIDERS OF SERVICES SOLELY ON  
18           BEHALF OF THE SPONSOR.—Officers  
19           or employees of a sponsor which is a  
20           service provider (other than a contract  
21           administrator) to the plan may be  
22           members of the board if they con-  
23           stitute not more than 25 percent of  
24           the membership of the board and they

1 do not provide services to the plan  
2 other than on behalf of the sponsor.

3 “(III) TREATMENT OF PRO-  
4 VIDERS OF MEDICAL CARE.—In the  
5 case of a sponsor which is an associa-  
6 tion whose membership consists pri-  
7 marily of providers of medical care,  
8 subclause (I) shall not apply in the  
9 case of any service provider described  
10 in subclause (I) who is a provider of  
11 medical care under the plan.

12 “(iii) CERTAIN PLANS EXCLUDED.—  
13 Clause (i) shall not apply to a small busi-  
14 ness health plan which is in existence on  
15 the date of the enactment of the Small  
16 Business Health Plans Act of 2008.

17 “(B) SOLE AUTHORITY.—The board has  
18 sole authority under the plan to approve appli-  
19 cations for participation in the plan and to con-  
20 tract with insurers.

21 “(c) TREATMENT OF FRANCHISES.—In the case of  
22 a group health plan which is established and maintained  
23 by a franchiser for a franchisor or for its franchisees—

24 “(1) the requirements of subsection (a) and sec-  
25 tion 801(a) shall be deemed met if such require-



1 based association, if at least one of the officers,  
2 directors, or employees of an employer, or at  
3 least one of the individuals who are partners in  
4 an employer and who actively participates in  
5 the business, is a member or such an affiliated  
6 member of the sponsor, participating employers  
7 may also include such employer; and

8 “(2) all individuals commencing coverage under  
9 the plan after certification under this part must  
10 be—

11 “(A) active or retired owners (including  
12 self-employed individuals), officers, directors, or  
13 employees of, or partners in, participating em-  
14 ployers; or

15 “(B) the dependents of individuals de-  
16 scribed in subparagraph (A).

17 “(b) INDIVIDUAL MARKET UNAFFECTED.—The re-  
18 quirements of this subsection are met with respect to a  
19 small business health plan if, under the terms of the plan,  
20 no participating employer may provide health insurance  
21 coverage in the individual market for any employee not  
22 covered under the plan which is similar to the coverage  
23 contemporaneously provided to employees of the employer  
24 under the plan, if such exclusion of the employee from cov-  
25 erage under the plan is based on a health status-related

1 factor with respect to the employee and such employee  
2 would, but for such exclusion on such basis, be eligible  
3 for coverage under the plan.

4 “(c) PROHIBITION OF DISCRIMINATION AGAINST EM-  
5 PLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—

6 The requirements of this subsection are met with respect  
7 to a small business health plan if—

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

16 “(2) information regarding all coverage options  
17 available under the plan is made readily available to  
18 any employer eligible to participate; and

19 “(3) the applicable requirements of sections  
20 701, 702, and 703 are met with respect to the plan.

1 **“SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN**  
2 **DOCUMENTS, CONTRIBUTION RATES, AND**  
3 **BENEFIT OPTIONS.**

4 “(a) IN GENERAL.—The requirements of this section  
5 are met with respect to a small business health plan if  
6 the following requirements are met:

7 “(1) CONTENTS OF GOVERNING INSTRU-  
8 MENTS.—

9 “(A) IN GENERAL.—The instruments gov-  
10 erning the plan include a written instrument,  
11 meeting the requirements of an instrument re-  
12 quired under section 402(a)(1), which—

13 “(i) provides that the board of trust-  
14 ees serves as the named fiduciary required  
15 for plans under section 402(a)(1) and  
16 serves in the capacity of a plan adminis-  
17 trator (referred to in section 3(16)(A));  
18 and

19 “(ii) provides that the sponsor of the  
20 plan is to serve as plan sponsor (referred  
21 to in section 3(16)(B)).

22 “(B) DESCRIPTION OF MATERIAL PROVI-  
23 SIONS.—The terms of the health insurance cov-  
24 erage (including the terms of any individual  
25 certificates that may be offered to individuals in  
26 connection with such coverage) describe the ma-

1           terial benefit and rating, and other provisions  
2           set forth in this section and such material pro-  
3           visions are included in the summary plan de-  
4           scription.

5           “(2) CONTRIBUTION RATES MUST BE NON-  
6           DISCRIMINATORY.—

7                   “(A) IN GENERAL.—The contribution rates  
8           for any participating small employer shall not  
9           vary on the basis of any health status-related  
10          factor in relation to employees of such employer  
11          or their beneficiaries and shall not vary on the  
12          basis of the type of business or industry in  
13          which such employer is engaged, subject to sub-  
14          paragraph (B) and the terms of this title.

15                  “(B) EFFECT OF TITLE.—Nothing in this  
16          title or any other provision of law shall be con-  
17          strued to preclude a health insurance issuer of-  
18          fering health insurance coverage in connection  
19          with a small business health plan that meets  
20          the requirements of this part, and at the re-  
21          quest of such small business health plan,  
22          from—

23                          “(i) setting contribution rates for the  
24                          small business health plan based on the  
25                          claims experience of the small business

1 health plan so long as any variation in  
2 such rates for participating small employ-  
3 ers complies with the requirements of  
4 clause (ii), except that small business  
5 health plans shall not be subject, in non-  
6 adopting states, to subparagraphs (A)(ii)  
7 and (C) of section 2912(a)(2) of the Public  
8 Health Service Act, and in adopting states,  
9 to any State law that would have the effect  
10 of imposing requirements as outlined in  
11 such subparagraphs (A)(ii) and (C); or

12 “(ii) varying contribution rates for  
13 participating small employers in a small  
14 business health plan in a State to the ex-  
15 tent that such rates could vary using the  
16 same methodology employed in such State  
17 for regulating small group premium rates,  
18 subject to the terms of part I of subtitle A  
19 of title XXIX of the Public Health Service  
20 Act (relating to rating requirements), as  
21 added by title II of the Small Business  
22 Health Plans Act of 2008.

23 “(3) EXCEPTIONS REGARDING SELF-EMPLOYED  
24 AND LARGE EMPLOYERS.—

25 “(A) SELF EMPLOYED.—

1           “(i) IN GENERAL.—Small business  
2           health plans with participating employers  
3           who are self-employed individuals (and  
4           their dependents) shall enroll such self-em-  
5           ployed participating employers in accord-  
6           ance with rating rules that do not violate  
7           the rating rules for self-employed individ-  
8           uals in the State in which such self-em-  
9           ployed participating employers are located.

10           “(ii) GUARANTEE ISSUE.—Small busi-  
11           ness health plans with participating em-  
12           ployers who are self-employed individuals  
13           (and their dependents) may decline to  
14           guarantee issue to such participating em-  
15           ployers in States in which guarantee issue  
16           is not otherwise required for the self-em-  
17           ployed in that State.

18           “(B) LARGE EMPLOYERS.—Small business  
19           health plans with participating employers that  
20           are larger than small employers (as defined in  
21           section 808(a)(10)) shall enroll such large par-  
22           ticipating employers in accordance with rating  
23           rules that do not violate the rating rules for  
24           large employers in the State in which such large  
25           participating employers are located.

1           “(4) REGULATORY REQUIREMENTS.—Such  
2 other requirements as the applicable authority deter-  
3 mines are necessary to carry out the purposes of this  
4 part, which shall be prescribed by the applicable au-  
5 thority by regulation.

6           “(b) ABILITY OF SMALL BUSINESS HEALTH PLANS  
7 TO DESIGN BENEFIT OPTIONS.—Nothing in this part or  
8 any provision of State law (as defined in section  
9 514(c)(1)) shall be construed to preclude a small business  
10 health plan or a health insurance issuer offering health  
11 insurance coverage in connection with a small business  
12 health plan from exercising its sole discretion in selecting  
13 the specific benefits and services consisting of medical care  
14 to be included as benefits under such plan or coverage,  
15 except that such benefits and services must meet the terms  
16 and specifications of part II of subtitle A of title XXIX  
17 of the Public Health Service Act (relating to lower cost  
18 plans), as added by title II of the Small Business Health  
19 Plans Act of 2008.

20           “(c) DOMICILE AND NON-DOMICILE STATES.—

21           “(1) DOMICILE STATE.—Coverage shall be  
22 issued to a small business health plan in the State  
23 in which the sponsor’s principal place of business is  
24 located.

1           “(2) NON-DOMICILE STATES.—With respect to  
2           a State (other than the domicile State) in which par-  
3           ticipating employers of a small business health plan  
4           are located but in which the insurer of the small  
5           business health plan in the domicile State is not yet  
6           licensed, the following shall apply:

7                   “(A) TEMPORARY PREEMPTION.—If, upon  
8                   the expiration of the 90-day period following  
9                   the submission of a licensure application by  
10                  such insurer (that includes a certified copy of  
11                  an approved licensure application as submitted  
12                  by such insurer in the domicile State) to such  
13                  State, such State has not approved or denied  
14                  such application, such State’s health insurance  
15                  licensure laws shall be temporarily preempted  
16                  and the insurer shall be permitted to operate in  
17                  such State, subject to the following terms:

18                           “(i) APPLICATION OF NON-DOMICILE  
19                           STATE LAW.—Except with respect to licen-  
20                           sure and with respect to the terms of sub-  
21                           title A of title XXIX of the Public Health  
22                           Service Act (relating to rating and benefits  
23                           as added by the Small Business Health  
24                           Plans Act of 2008), the laws and authority

1 of the non-domicile State shall remain in  
2 full force and effect.

3 “(ii) REVOCATION OF PREEMPTION.—  
4 The preemption of a non-domicile State’s  
5 health insurance licensure laws pursuant to  
6 this subparagraph, shall be terminated  
7 upon the occurrence of either of the fol-  
8 lowing:

9 “(I) APPROVAL OR DENIAL OF  
10 APPLICATION.—The approval or denial  
11 of an insurer’s licensure application,  
12 following the laws and regulations of  
13 the non-domicile State with respect to  
14 licensure.

15 “(II) DETERMINATION OF MATE-  
16 RIAL VIOLATION.—A determination by  
17 a non-domicile State that an insurer  
18 operating in a non-domicile State pur-  
19 suant to the preemption provided for  
20 in this subparagraph is in material  
21 violation of the insurance laws (other  
22 than licensure and with respect to the  
23 terms of subtitle A of title XXIX of  
24 the Public Health Service Act (relat-  
25 ing to rating and benefits added by

1 the Small Business Health Plans Act  
2 of 2008)) of such State.

3 “(B) NO PROHIBITION ON PROMOTION.—  
4 Nothing in this paragraph shall be construed to  
5 prohibit a small business health plan or an in-  
6 surer from promoting coverage prior to the ex-  
7 piration of the 90-day period provided for in  
8 subparagraph (A), except that no enrollment or  
9 collection of contributions shall occur before the  
10 expiration of such 90-day period.

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

18 “(D) SERVICING BY LICENSED INSUR-  
19 ERS.—Notwithstanding subparagraph (C), the  
20 requirements of this subsection may also be sat-  
21 isfied if the participating employers of a small  
22 business health plan are serviced by a licensed  
23 insurer in that State, even where such insurer  
24 is not the insurer of such small business health

1           plan in the State in which such small business  
2           health plan is domiciled.

3 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
4 **LATED REQUIREMENTS.**

5           “(a) **FILING FEE.**—Under the procedure prescribed  
6 pursuant to section 802(a), a small business health plan  
7 shall pay to the applicable authority at the time of filing  
8 an application for certification under this part a filing fee  
9 in the amount of \$5,000, which shall be available in the  
10 case of the Secretary, to the extent provided in appropria-  
11 tion Acts, for the sole purpose of administering the certifi-  
12 cation procedures applicable with respect to small business  
13 health plans.

14           “(b) **INFORMATION TO BE INCLUDED IN APPLICA-**  
15 **TION FOR CERTIFICATION.**—An application for certifi-  
16 cation under this part meets the requirements of this sec-  
17 tion only if it includes, in a manner and form which shall  
18 be prescribed by the applicable authority by regulation, at  
19 least the following information:

20           “(1) **IDENTIFYING INFORMATION.**—The names  
21 and addresses of—

22                   “(A) the sponsor; and

23                   “(B) the members of the board of trustees  
24 of the plan.

1           “(2) STATES IN WHICH PLAN INTENDS TO DO  
2 BUSINESS.—The States in which participants and  
3 beneficiaries under the plan are to be located and  
4 the number of them expected to be located in each  
5 such State.

6           “(3) BONDING REQUIREMENTS.—Evidence pro-  
7 vided by the board of trustees that the bonding re-  
8 quirements of section 412 will be met as of the date  
9 of the application or (if later) commencement of op-  
10 erations.

11           “(4) PLAN DOCUMENTS.—A copy of the docu-  
12 ments governing the plan (including any bylaws and  
13 trust agreements), the summary plan description,  
14 and other material describing the benefits that will  
15 be provided to participants and beneficiaries under  
16 the plan.

17           “(5) AGREEMENTS WITH SERVICE PRO-  
18 VIDERS.—A copy of any agreements between the  
19 plan, health insurance issuer, and contract adminis-  
20 trators and other service providers.

21           “(c) FILING NOTICE OF CERTIFICATION WITH  
22 STATES.—A certification granted under this part to a  
23 small business health plan shall not be effective unless  
24 written notice of such certification is filed with the appli-

1 cable State authority of each State in which the small  
2 business health plans operate.

3 “(d) NOTICE OF MATERIAL CHANGES.—In the case  
4 of any small business health plan certified under this part,  
5 descriptions of material changes in any information which  
6 was required to be submitted with the application for the  
7 certification under this part shall be filed in such form  
8 and manner as shall be prescribed by the applicable au-  
9 thority by regulation. The applicable authority may re-  
10 quire by regulation prior notice of material changes with  
11 respect to specified matters which might serve as the basis  
12 for suspension or revocation of the certification.

13 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
14 **MINATION.**

15 “A small business health plan which is or has been  
16 certified under this part may terminate (upon or at any  
17 time after cessation of accruals in benefit liabilities) only  
18 if the board of trustees, not less than 60 days before the  
19 proposed termination date—

20 “(1) provides to the participants and bene-  
21 ficiaries a written notice of intent to terminate stat-  
22 ing that such termination is intended and the pro-  
23 posed termination date;

24 “(2) develops a plan for winding up the affairs  
25 of the plan in connection with such termination in

1 a manner which will result in timely payment of all  
2 benefits for which the plan is obligated; and

3 “(3) submits such plan in writing to the appli-  
4 cable authority.

5 Actions required under this section shall be taken in such  
6 form and manner as may be prescribed by the applicable  
7 authority by regulation.

8 **“SEC. 809. IMPLEMENTATION AND APPLICATION AUTHOR-  
9 ITY BY SECRETARY.**

10 “The Secretary shall, through promulgation and im-  
11 plementation of such regulations as the Secretary may  
12 reasonably determine necessary or appropriate, and in  
13 consultation with a balanced spectrum of effected entities  
14 and persons, modify the implementation and application  
15 of this part to accommodate with minimum disruption  
16 such changes to State or Federal law provided in this part  
17 and the (and the amendments made by such Act) or in  
18 regulations issued thereto.

19 **“SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.**

20 “(a) DEFINITIONS.—For purposes of this part—

21 “(1) AFFILIATED MEMBER.—The term ‘affili-  
22 ated member’ means, in connection with a sponsor—

23 “(A) a person who is otherwise eligible to  
24 be a member of the sponsor but who elects an  
25 affiliated status with the sponsor, or

1           “(B) in the case of a sponsor with mem-  
2           bers which consist of associations, a person who  
3           is a member or employee of any such associa-  
4           tion and elects an affiliated status with the  
5           sponsor.

6           “(2) APPLICABLE AUTHORITY.—The term ‘ap-  
7           plicable authority’ means the Secretary of Labor, ex-  
8           cept that, in connection with any exercise of the Sec-  
9           retary’s authority with respect to which the Sec-  
10          retary is required under section 506(d) to consult  
11          with a State, such term means the Secretary, in con-  
12          sultation with such State.

13          “(3) APPLICABLE STATE AUTHORITY.—The  
14          term ‘applicable State authority’ means, with respect  
15          to a health insurance issuer in a State, the State in-  
16          surance commissioner or official or officials des-  
17          ignated by the State to enforce the requirements of  
18          title XXVII of the Public Health Service Act for the  
19          State involved with respect to such issuer.

20          “(4) GROUP HEALTH PLAN.—The term ‘group  
21          health plan’ has the meaning provided in section  
22          733(a)(1) (after applying subsection (b) of this sec-  
23          tion).

24          “(5) HEALTH INSURANCE COVERAGE.—The  
25          term ‘health insurance coverage’ has the meaning

1 provided in section 733(b)(1), except that such term  
2 shall not include excepted benefits (as defined in sec-  
3 tion 733(c)).

4 “(6) HEALTH INSURANCE ISSUER.—The term  
5 ‘health insurance issuer’ has the meaning provided  
6 in section 733(b)(2).

7 “(7) INDIVIDUAL MARKET.—

8 “(A) IN GENERAL.—The term ‘individual  
9 market’ means the market for health insurance  
10 coverage offered to individuals other than in  
11 connection with a group health plan.

12 “(B) TREATMENT OF VERY SMALL  
13 GROUPS.—

14 “(i) IN GENERAL.—Subject to clause  
15 (ii), such term includes coverage offered in  
16 connection with a group health plan that  
17 has fewer than 2 participants as current  
18 employees or participants described in sec-  
19 tion 732(d)(3) on the first day of the plan  
20 year.

21 “(ii) STATE EXCEPTION.—Clause (i)  
22 shall not apply in the case of health insur-  
23 ance coverage offered in a State if such  
24 State regulates the coverage described in  
25 such clause in the same manner and to the

1 same extent as coverage in the small group  
2 market (as defined in section 2791(e)(5) of  
3 the Public Health Service Act) is regulated  
4 by such State.

5 “(8) MEDICAL CARE.—The term ‘medical care’  
6 has the meaning provided in section 733(a)(2).

7 “(9) PARTICIPATING EMPLOYER.—The term  
8 ‘participating employer’ means, in connection with a  
9 small business health plan, any employer, if any in-  
10 dividual who is an employee of such employer, a  
11 partner in such employer, or a self-employed indi-  
12 vidual who is such employer (or any dependent, as  
13 defined under the terms of the plan, of such indi-  
14 vidual) is or was covered under such plan in connec-  
15 tion with the status of such individual as such an  
16 employee, partner, or self-employed individual in re-  
17 lation to the plan.

18 “(10) SMALL EMPLOYER.—The term ‘small em-  
19 ployer’ means, in connection with a group health  
20 plan with respect to a plan year, a small employer  
21 as defined in section 2791(e)(4).

22 “(11) TRADE ASSOCIATION AND PROFESSIONAL  
23 ASSOCIATION.—The terms ‘trade association’ and  
24 ‘professional association’ mean an entity that meets  
25 the requirements of section 1.501(c)(6)–1 of title 26,

1 Code of Federal Regulations (as in effect on the  
2 date of enactment of this Act).

3 “(b) RULE OF CONSTRUCTION.—For purposes of de-  
4 termining whether a plan, fund, or program is an em-  
5 ployee welfare benefit plan which is a small business  
6 health plan, and for purposes of applying this title in con-  
7 nection with such plan, fund, or program so determined  
8 to be such an employee welfare benefit plan—

9 “(1) in the case of a partnership, the term ‘em-  
10 ployer’ (as defined in section 3(5)) includes the part-  
11 nership in relation to the partners, and the term  
12 ‘employee’ (as defined in section 3(6)) includes any  
13 partner in relation to the partnership; and

14 “(2) in the case of a self-employed individual,  
15 the term ‘employer’ (as defined in section 3(5)) and  
16 the term ‘employee’ (as defined in section 3(6)) shall  
17 include such individual.

18 “(c) RENEWAL.—Notwithstanding any provision of  
19 law to the contrary, a participating employer in a small  
20 business health plan shall not be deemed to be a plan  
21 sponsor in applying requirements relating to coverage re-  
22 newal.

23 “(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this  
24 part shall be construed to create any mandates for cov-  
25 erage of benefits for HSA-qualified health plans that

1 would require reimbursements in violation of section  
2 223(c)(2) of the Internal Revenue Code of 1986.”.

3 (b) CONFORMING AMENDMENTS TO PREEMPTION  
4 RULES.—

5 (1) Section 514(b)(6) of such Act (29 U.S.C.  
6 1144(b)(6)) is amended by adding at the end the  
7 following new subparagraph:

8 “(E) The preceding subparagraphs of this paragraph  
9 do not apply with respect to any State law in the case  
10 of a small business health plan which is certified under  
11 part 8.”.

12 (2) Section 514 of such Act (29 U.S.C. 1144)  
13 is amended—

14 (A) in subsection (b)(4), by striking “Sub-  
15 section (a)” and inserting “Subsections (a) and  
16 (d)”;

17 (B) in subsection (b)(5), by striking “sub-  
18 section (a)” in subparagraph (A) and inserting  
19 “subsection (a) of this section and subsections  
20 (a)(2)(B) and (b) of section 805”, and by strik-  
21 ing “subsection (a)” in subparagraph (B) and  
22 inserting “subsection (a) of this section or sub-  
23 section (a)(2)(B) or (b) of section 805”;

24 (C) by redesignating subsection (d) as sub-  
25 section (e); and

1 (D) by inserting after subsection (c) the  
2 following new subsection:

3 “(d)(1) Except as provided in subsection (b)(4), the  
4 provisions of this title shall supersede any and all State  
5 laws insofar as they may now or hereafter preclude a  
6 health insurance issuer from offering health insurance cov-  
7 erage in connection with a small business health plan  
8 which is certified under part 8.

9 “(2) In any case in which health insurance coverage  
10 of any policy type is offered under a small business health  
11 plan certified under part 8 to a participating employer op-  
12 erating in such State, the provisions of this title shall su-  
13 percede any and all laws of such State insofar as they may  
14 establish rating and benefit requirements that would oth-  
15 erwise apply to such coverage, provided the requirements  
16 of subtitle A of title XXIX of the Public Health Service  
17 Act (as added by title II of the Health Insurance Market-  
18 place Modernization and Affordability Act of 2007) (con-  
19 cerning health plan rating and benefits) are met.”.

20 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
21 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
22 the following new sentence: “Such term also includes a  
23 person serving as the sponsor of a small business health  
24 plan under part 8.”.

1 (d) SAVINGS CLAUSE.—Section 731(e) of such Act  
2 is amended by inserting “or part 8” after “this part”.

3 (e) CLERICAL AMENDMENT.—The table of contents  
4 in section 1 of the Employee Retirement Income Security  
5 Act of 1974 is amended by inserting after the item relat-  
6 ing to section 734 the following new items:

“PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

“801. Small business health plans.

“802. Alternative market pooling organizations.

“803. Certification of small business health plans.

“804. Requirements relating to sponsors and boards of trustees.

“805. Participation and coverage requirements.

“806. Other requirements relating to plan documents, contribution rates, and  
benefit options.

“807. Requirements for application and related requirements.

“808. Notice requirements for voluntary termination.

“809. Implementation and application authority by Secretary.

“810. Definitions and rules of construction.”.

7 **SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE**  
8 **AUTHORITIES.**

9 Section 506 of the Employee Retirement Income Se-  
10 curity Act of 1974 (29 U.S.C. 1136) is amended by adding  
11 at the end the following new subsection:

12 “(d) CONSULTATION WITH STATES WITH RESPECT  
13 TO SMALL BUSINESS HEALTH PLANS.—

14 “(1) AGREEMENTS WITH STATES.—The Sec-  
15 retary shall consult with the State recognized under  
16 paragraph (2) with respect to a small business  
17 health plan regarding the exercise of—

1           “(A) the Secretary’s authority under sec-  
2           tions 502 and 504 to enforce the requirements  
3           for certification under part 8; and

4           “(B) the Secretary’s authority to certify  
5           small business health plans under part 8 in ac-  
6           cordance with regulations of the Secretary ap-  
7           plicable to certification under part 8.

8           “(2) RECOGNITION OF DOMICILE STATE.—In  
9           carrying out paragraph (1), the Secretary shall en-  
10          sure that only one State will be recognized, with re-  
11          spect to any particular small business health plan,  
12          as the State with which consultation is required. In  
13          carrying out this paragraph such State shall be the  
14          domicile State, as defined in section 805(c).”.

15 **SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND**  
16 **OTHER RULES.**

17          (a) **EFFECTIVE DATE.**—The amendments made by  
18 this title shall take effect 12 months after the date of the  
19 enactment of this Act. The Secretary of Labor shall first  
20 issue all regulations necessary to carry out the amend-  
21 ments made by this title within 6 months after the date  
22 of the enactment of this Act.

23          (b) **TREATMENT OF CERTAIN EXISTING HEALTH**  
24 **BENEFITS PROGRAMS.**—

1           (1) IN GENERAL.—In any case in which, as of  
2           the date of the enactment of this Act, an arrange-  
3           ment is maintained in a State for the purpose of  
4           providing benefits consisting of medical care for the  
5           employees and beneficiaries of its participating em-  
6           ployers, at least 200 participating employers make  
7           contributions to such arrangement, such arrange-  
8           ment has been in existence for at least 10 years, and  
9           such arrangement is licensed under the laws of one  
10          or more States to provide such benefits to its par-  
11          ticipating employers, upon the filing with the appli-  
12          cable authority (as defined in section 808(a)(2) of  
13          the Employee Retirement Income Security Act of  
14          1974 (as amended by this subtitle)) by the arrange-  
15          ment of an application for certification of the ar-  
16          rangement under part 8 of subtitle B of title I of  
17          such Act—

18                   (A) such arrangement shall be deemed to  
19                   be a group health plan for purposes of title I  
20                   of such Act;

21                   (B) the requirements of sections 801(a)  
22                   and 803(a) of the Employee Retirement Income  
23                   Security Act of 1974 shall be deemed met with  
24                   respect to such arrangement;

1           (C) the requirements of section 803(b) of  
2 such Act shall be deemed met, if the arrange-  
3 ment is operated by a board of trustees which  
4 has control over the arrangement;

5           (D) the requirements of section 804(a) of  
6 such Act shall be deemed met with respect to  
7 such arrangement; and

8           (E) the arrangement may be certified by  
9 any applicable authority with respect to its op-  
10 erations in any State only if it operates in such  
11 State on the date of certification.

12       The provisions of this subsection shall cease to apply  
13 with respect to any such arrangement at such time  
14 after the date of the enactment of this Act as the  
15 applicable requirements of this subsection are not  
16 met with respect to such arrangement or at such  
17 time that the arrangement provides coverage to par-  
18 ticipants and beneficiaries in any State other than  
19 the States in which coverage is provided on such  
20 date of enactment.

21       (2) DEFINITIONS.—For purposes of this sub-  
22 section, the terms “group health plan”, “medical  
23 care”, and “participating employer” shall have the  
24 meanings provided in section 808 of the Employee  
25 Retirement Income Security Act of 1974, except

1 that the reference in paragraph (7) of such section  
 2 to an “small business health plan” shall be deemed  
 3 a reference to an arrangement referred to in this  
 4 subsection.

## 5 **TITLE II—MARKET RELIEF**

### 6 **SEC. 301. MARKET RELIEF.**

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

## 9 **“TITLE XXIX—HEALTH CARE IN-** 10 **SURANCE MARKETPLACE** 11 **MODERNIZATION**

### 12 **“SEC. 2901. GENERAL INSURANCE DEFINITIONS.**

13 “In this title, the terms ‘health insurance coverage’,  
 14 ‘health insurance issuer’, ‘group health plan’, and ‘indi-  
 15 vidual health insurance’ shall have the meanings given  
 16 such terms in section 2791.

### 17 **“SEC. 2902. IMPLEMENTATION AND APPLICATION AUTHOR-** 18 **ITY BY SECRETARY.**

19 “The Secretary shall, through promulgation and im-  
 20 plementation of such regulations as the Secretary may  
 21 reasonably determine necessary or appropriate, and in  
 22 consultation with a balanced spectrum of effected entities  
 23 and persons, modify the implementation and application  
 24 of this title to accommodate with minimum disruption  
 25 such changes to State or Federal law provided in this title

1 and the (and the amendments made by such Act) or in  
 2 regulations issued thereto.

## 3 **“Subtitle A—Market Relief**

### 4 **“PART I—RATING REQUIREMENTS**

#### 5 **“SEC. 2911. DEFINITIONS.**

6 “In this part:

7 “(1) **ADOPTING STATE.**—The term ‘adopting  
 8 State’ means a State that, with respect to the small  
 9 group market, has enacted small group rating rules  
 10 that meet the minimum standards set forth in sec-  
 11 tion 2912(a)(1) or, as applicable, transitional small  
 12 group rating rules set forth in section 2912(b).

13 “(2) **APPLICABLE STATE AUTHORITY.**—The  
 14 term ‘applicable State authority’ means, with respect  
 15 to a health insurance issuer in a State, the State in-  
 16 surance commissioner or official or officials des-  
 17 ignated by the State to enforce the insurance laws  
 18 of such State.

19 “(3) **BASE PREMIUM RATE.**—The term ‘base  
 20 premium rate’ means, for each class of business with  
 21 respect to a rating period, the lowest premium rate  
 22 charged or that could have been charged under a  
 23 rating system for that class of business by the small  
 24 employer carrier to small employers with similar

1 case characteristics for health benefit plans with the  
2 same or similar coverage.

3 “(4) ELIGIBLE INSURER.—The term ‘eligible  
4 insurer’ means a health insurance issuer that is li-  
5 censed in a State and that—

6 “(A) notifies the Secretary, not later than  
7 30 days prior to the offering of coverage de-  
8 scribed in this subparagraph, that the issuer in-  
9 tends to offer health insurance coverage con-  
10 sistent with the Model Small Group Rating  
11 Rules or, as applicable, transitional small group  
12 rating rules in a State;

13 “(B) notifies the insurance department of  
14 a nonadopting State (or other State agency),  
15 not later than 30 days prior to the offering of  
16 coverage described in this subparagraph, that  
17 the issuer intends to offer small group health  
18 insurance coverage in that State consistent with  
19 the Model Small Group Rating Rules, and pro-  
20 vides with such notice a copy of any insurance  
21 policy that it intends to offer in the State, its  
22 most recent annual and quarterly financial re-  
23 ports, and any other information required to be  
24 filed with the insurance department of the State  
25 (or other State agency); and

1           “(C) includes in the terms of the health in-  
2           surance coverage offered in nonadopting States  
3           (including in the terms of any individual certifi-  
4           cates that may be offered to individuals in con-  
5           nection with such group health coverage) and  
6           filed with the State pursuant to subparagraph  
7           (B), a description in the insurer’s contract of  
8           the Model Small Group Rating Rules and an af-  
9           firmation that such Rules are included in the  
10          terms of such contract.

11          “(5) HEALTH INSURANCE COVERAGE.—The  
12          term ‘health insurance coverage’ means any coverage  
13          issued in the small group health insurance market,  
14          except that such term shall not include excepted  
15          benefits (as defined in section 2791(c)).

16          “(6) INDEX RATE.—The term ‘index rate’  
17          means for each class of business with respect to the  
18          rating period for small employers with similar case  
19          characteristics, the arithmetic average of the appli-  
20          cable base premium rate and the corresponding  
21          highest premium rate.

22          “(7) MODEL SMALL GROUP RATING RULES.—  
23          The term ‘Model Small Group Rating Rules’ means  
24          the rules set forth in section 2912(a)(2).

1           “(8) NONADOPTING STATE.—The term ‘non-  
2     adopting State’ means a State that is not an adopt-  
3     ing State.

4           “(9) SMALL GROUP INSURANCE MARKET.—The  
5     term ‘small group insurance market’ shall have the  
6     meaning given the term ‘small group market’ in sec-  
7     tion 2791(e)(5).

8           “(10) STATE LAW.—The term ‘State law’  
9     means all laws, decisions, rules, regulations, or other  
10    State actions (including actions by a State agency)  
11    having the effect of law, of any State.

12           “(11) VARIATION LIMITS.—

13           “(A) COMPOSITE VARIATION LIMIT.—

14           “(i) IN GENERAL.—The term ‘com-  
15     posite variation limit’ means the total vari-  
16     ation in premium rates charged by a  
17     health insurance issuer in the small group  
18     market as permitted under applicable State  
19     law based on the following factors or case  
20     characteristics:

21           “(I) Age.

22           “(II) Duration of coverage.

23           “(III) Claims experience.

24           “(IV) Health status.

1           “(ii) USE OF FACTORS.—With respect  
2           to the use of the factors described in  
3           clause (i) in setting premium rates, a  
4           health insurance issuer shall use one or  
5           both of the factors described in subclauses  
6           (I) or (IV) of such clause and may use the  
7           factors described in subclauses (II) or (III)  
8           of such clause.

9           “(B) TOTAL VARIATION LIMIT.—The term  
10          ‘total variation limit’ means the total variation  
11          in premium rates charged by a health insurance  
12          issuer in the small group market as permitted  
13          under applicable State law based on all factors  
14          and case characteristics (as described in section  
15          2912(a)(1)).

16 **“SEC. 2912. RATING RULES.**

17          “(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR  
18          PREMIUM VARIATIONS AND MODEL SMALL GROUP RAT-  
19          ING RULES.—Not later than 6 months after the date of  
20          enactment of this title, the Secretary shall promulgate reg-  
21          ulations establishing the following Minimum Standards  
22          and Model Small Group Rating Rules:

23                  “(1) MINIMUM STANDARDS FOR PREMIUM VARI-  
24          ATIONS.—

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

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

6           “(C) PROHIBITION ON USE OF CERTAIN  
7 CASE CHARACTERISTICS.—For purposes of this  
8 paragraph, in calculating the total variation  
9 limit, the State shall not use case characteris-  
10 tics other than those used in calculating the  
11 composite variation limit and industry, geo-  
12 graphic area, group size, participation rate,  
13 class of business, and participation in wellness  
14 programs.

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

18           “(A) PREMIUM RATES.—Premium rates  
19 for small group health benefit plans to which  
20 this title applies shall comply with the following  
21 provisions relating to premiums, except as pro-  
22 vided for under subsection (b):

23           “(i) VARIATION IN PREMIUM  
24 RATES.—The plan may not vary premium

1 rates by more than the minimum stand-  
2 ards provided for under paragraph (1).

3 “(ii) INDEX RATE.—The index rate  
4 for a rating period for any class of busi-  
5 ness shall not exceed the index rate for any  
6 other class of business by more than 20  
7 percent, excluding those classes of business  
8 related to association groups under this  
9 title.

10 “(iii) CLASS OF BUSINESSES.—With  
11 respect to a class of business, the premium  
12 rates charged during a rating period to  
13 small employers with similar case charac-  
14 teristics for the same or similar coverage  
15 or the rates that could be charged to such  
16 employers under the rating system for that  
17 class of business, shall not vary from the  
18 index rate by more than 25 percent of the  
19 index rate under clause (ii).

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

1           “(I) The percentage change in  
2           the new business premium rate meas-  
3           ured from the first day of the prior  
4           rating period to the first day of the  
5           new rating period. In the case of a  
6           health benefit plan into which the  
7           small employer carrier is no longer en-  
8           rolling new small employers, the small  
9           employer carrier shall use the percent-  
10          age change in the base premium rate,  
11          except that such change shall not ex-  
12          ceed, on a percentage basis, the  
13          change in the new business premium  
14          rate for the most similar health ben-  
15          efit plan into which the small em-  
16          ployer carrier is actively enrolling new  
17          small employers.

18           “(II) Any adjustment, not to ex-  
19          ceed 15 percent annually and adjusted  
20          pro rata for rating periods of less  
21          than 1 year, due to the claim experi-  
22          ence, health status or duration of cov-  
23          erage of the employees or dependents  
24          of the small employer as determined  
25          from the small employer carrier’s rate

1 manual for the class of business in-  
2 volved.

3 “(III) Any adjustment due to  
4 change in coverage or change in the  
5 case characteristics of the small em-  
6 ployer as determined from the small  
7 employer carrier’s rate manual for the  
8 class of business.

9 “(v) UNIFORM APPLICATION OF AD-  
10 JUSTMENTS.—Adjustments in premium  
11 rates for claim experience, health status, or  
12 duration of coverage shall not be charged  
13 to individual employees or dependents. Any  
14 such adjustment shall be applied uniformly  
15 to the rates charged for all employees and  
16 dependents of the small employer.

17 “(vi) PROHIBITION ON USE OF CER-  
18 TAIN CASE CHARACTERISTIC.—A small em-  
19 ployer carrier shall not utilize case charac-  
20 teristics, other than those permitted under  
21 paragraph (1)(C), without the prior ap-  
22 proval of the applicable State authority.

23 “(vii) CONSISTENT APPLICATION OF  
24 FACTORS.—Small employer carriers shall  
25 apply rating factors, including case charac-

1           teristics, consistently with respect to all  
2           small employers in a class of business.  
3           Rating factors shall produce premiums for  
4           identical groups which differ only by the  
5           amounts attributable to plan design and do  
6           not reflect differences due to the nature of  
7           the groups assumed to select particular  
8           health benefit plans.

9           “(viii) TREATMENT OF PLANS AS HAV-  
10          ING SAME RATING PERIOD.—A small em-  
11          ployer carrier shall treat all health benefit  
12          plans issued or renewed in the same cal-  
13          endar month as having the same rating pe-  
14          riod.

15          “(ix) REQUIRE COMPLIANCE.—Pre-  
16          mium rates for small business health ben-  
17          efit plans shall comply with the require-  
18          ments of this subsection notwithstanding  
19          any assessments paid or payable by a small  
20          employer carrier as required by a State’s  
21          small employer carrier reinsurance pro-  
22          gram.

23          “(B) ESTABLISHMENT OF SEPARATE  
24          CLASS OF BUSINESS.—Subject to subparagraph  
25          (C), a small employer carrier may establish a

1 separate class of business only to reflect sub-  
2 stantial differences in expected claims experi-  
3 ence or administrative costs related to the fol-  
4 lowing:

5 “(i) The small employer carrier uses  
6 more than one type of system for the mar-  
7 keting and sale of health benefit plans to  
8 small employers.

9 “(ii) The small employer carrier has  
10 acquired a class of business from another  
11 small employer carrier.

12 “(iii) The small employer carrier pro-  
13 vides coverage to one or more association  
14 groups that meet the requirements of this  
15 title.

16 “(C) LIMITATION.—A small employer car-  
17 rier may establish up to 9 separate classes of  
18 business under subparagraph (B), excluding  
19 those classes of business related to association  
20 groups under this title.

21 “(D) LIMITATION ON TRANSFERS.—A  
22 small employer carrier shall not transfer a  
23 small employer involuntarily into or out of a  
24 class of business. A small employer carrier shall  
25 not offer to transfer a small employer into or

1 out of a class of business unless such offer is  
2 made to transfer all small employers in the  
3 class of business without regard to case charac-  
4 teristics, claim experience, health status or du-  
5 ration of coverage since issue.

6 “(b) TRANSITIONAL MODEL SMALL GROUP RATING  
7 RULES.—

8 “(1) IN GENERAL.—Not later than 6 months  
9 after the date of enactment of this title and to the  
10 extent necessary to provide for a graduated transi-  
11 tion to the minimum standards for premium vari-  
12 ation as provided for in subsection (a)(1), the Sec-  
13 retary, in consultation with the National Association  
14 of Insurance Commissioners (NAIC), shall promul-  
15 gate State-specific transitional small group rating  
16 rules in accordance with this subsection, which shall  
17 be applicable with respect to non-adopting States  
18 and eligible insurers operating in such States for a  
19 period of not to exceed 3 years from the date of the  
20 promulgation of the minimum standards for pre-  
21 mium variation pursuant to subsection (a).

22 “(2) COMPLIANCE WITH TRANSITIONAL MODEL  
23 SMALL GROUP RATING RULES.—During the transi-  
24 tion period described in paragraph (1), a State that,  
25 on the date of enactment of this title, has in effect

1 a small group rating rules methodology that allows  
2 for a variation that is less than the variation pro-  
3 vided for under subsection (a)(1) (concerning min-  
4 imum standards for premium variation), shall be  
5 deemed to be an adopting State if the State complies  
6 with the transitional small group rating rules as pro-  
7 mulgated by the Secretary pursuant to paragraph  
8 (1).

9 “(3) TRANSITIONING OF OLD BUSINESS.—

10 “(A) IN GENERAL.—In developing the  
11 transitional small group rating rules under  
12 paragraph (1), the Secretary shall, after con-  
13 sultation with the National Association of In-  
14 surance Commissioners and representatives of  
15 insurers operating in the small group health in-  
16 surance market in non-adopting States, promul-  
17 gate special transition standards with respect to  
18 independent rating classes for old and new busi-  
19 ness, to the extent reasonably necessary to pro-  
20 tect health insurance consumers and to ensure  
21 a stable and fair transition for old and new  
22 market entrants.

23 “(B) PERIOD FOR OPERATION OF INDE-  
24 PENDENT RATING CLASSES.—In developing the  
25 special transition standards pursuant to sub-

1 paragraph (A), the Secretary shall permit a  
2 carrier in a non-adopting State, at its option, to  
3 maintain independent rating classes for old and  
4 new business for a period of up to 5 years, with  
5 the commencement of such 5-year period to  
6 begin at such time, but not later than the date  
7 that is 3 years after the date of enactment of  
8 this title, as the carrier offers a book of busi-  
9 ness meeting the minimum standards for pre-  
10 mium variation provided for in subsection  
11 (a)(1) or the transitional small group rating  
12 rules under paragraph (1).

13 “(4) OTHER TRANSITIONAL AUTHORITY.—In  
14 developing the transitional small group rating rules  
15 under paragraph (1), the Secretary shall provide for  
16 the application of the transitional small group rating  
17 rules in transition States as the Secretary may de-  
18 termine necessary for a an effective transition.

19 “(c) MARKET RE-ENTRY.—

20 “(1) IN GENERAL.—Notwithstanding any other  
21 provision of law, a health insurance issuer that has  
22 voluntarily withdrawn from providing coverage in the  
23 small group market prior to the date of enactment  
24 of the Small Business Health Plans Act of 2008  
25 shall not be excluded from re-entering such market

1 on a date that is more than 180 days after such  
2 date of enactment.

3 “(2) TERMINATION.—The provision of this sub-  
4 section shall terminate on the date that is 24  
5 months after the date of enactment of the Small  
6 Business Health Plans Act of 2008.

7 **“SEC. 2913. APPLICATION AND PREEMPTION.**

8 “(a) SUPERSEDING OF STATE LAW.—

9 “(1) IN GENERAL.—This part shall supersede  
10 any and all State laws of a non-adopting State inso-  
11 far as such State laws (whether enacted prior to or  
12 after the date of enactment of this subtitle) relate to  
13 rating in the small group insurance market as ap-  
14 plied to an eligible insurer, or small group health in-  
15 surance coverage issued by an eligible insurer, in-  
16 cluding with respect to coverage issued to a small  
17 employer through a small business health plan, in a  
18 State.

19 “(2) NONADOPTING STATES.—This part shall  
20 supersede any and all State laws of a nonadopting  
21 State insofar as such State laws (whether enacted  
22 prior to or after the date of enactment of this sub-  
23 title)—

24 “(A) prohibit an eligible insurer from of-  
25 fering, marketing, or implementing small group

1 health insurance coverage consistent with the  
2 Model Small Group Rating Rules or transitional  
3 model small group rating rules; or

4 “(B) have the effect of retaliating against  
5 or otherwise punishing in any respect an eligible  
6 insurer for offering, marketing, or imple-  
7 menting small group health insurance coverage  
8 consistent with the Model Small Group Rating  
9 Rules or transitional model small group rating  
10 rules.

11 “(b) SAVINGS CLAUSE AND CONSTRUCTION.—

12 “(1) NONAPPLICATION TO ADOPTING STATES.—  
13 Subsection (a) shall not apply with respect to adopt-  
14 ing states.

15 “(2) NONAPPLICATION TO CERTAIN INSUR-  
16 ERS.—Subsection (a) shall not apply with respect to  
17 insurers that do not qualify as eligible insurers that  
18 offer small group health insurance coverage in a  
19 nonadopting State.

20 “(3) NONAPPLICATION WHERE OBTAINING RE-  
21 LIEF UNDER STATE LAW.—Subsection (a)(1) shall  
22 not supercede any State law in a nonadopting State  
23 to the extent necessary to permit individuals or the  
24 insurance department of the State (or other State  
25 agency) to obtain relief under State law to require

1 an eligible insurer to comply with the Model Small  
2 Group Rating Rules or transitional model small  
3 group rating rules.

4 “(4) NO EFFECT ON PREEMPTION.—In no case  
5 shall this part be construed to limit or affect in any  
6 manner the preemptive scope of sections 502 and  
7 514 of the Employee Retirement Income Security  
8 Act of 1974. In no case shall this part be construed  
9 to create any cause of action under Federal or State  
10 law or enlarge or affect any remedy available under  
11 the Employee Retirement Income Security Act of  
12 1974.

13 “(5) PREEMPTION LIMITED TO RATING.—Sub-  
14 section (a) shall not preempt any State law that  
15 does not have a reference to or a connection with  
16 State rating rules that would otherwise apply to eli-  
17 gible insurers.

18 “(c) EFFECTIVE DATE.—This section shall apply, at  
19 the election of the eligible insurer, beginning in the first  
20 plan year or the first calendar year following the issuance  
21 of the final rules by the Secretary under the Model Small  
22 Group Rating Rules or, as applicable, the Transitional  
23 Model Small Group Rating Rules, but in no event earlier  
24 than the date that is 12 months after the date of enact-  
25 ment of this title.

1 **“SEC. 2914. CIVIL ACTIONS AND JURISDICTION.**

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

5 “(b) ACTIONS.—An eligible insurer may bring an ac-  
6 tion in the district courts of the United States for injunc-  
7 tive or other equitable relief against any officials or agents  
8 of a nonadopting State in connection with any conduct or  
9 action, or proposed conduct or action, by such officials or  
10 agents which violates, or which would if undertaken vio-  
11 late, section 2913.

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

18 “(d) EXPEDITED REVIEW.—

19 “(1) DISTRICT COURT.—In the case of an ac-  
20 tion brought in a district court of the United States  
21 under subsection (b), such court shall complete such  
22 action, including the issuance of a judgment, prior  
23 to the end of the 120-day period beginning on the  
24 date on which such action is filed, unless all parties  
25 to such proceeding agree to an extension of such pe-  
26 riod.

1           “(2) COURT OF APPEALS.—In the case of an  
2           action brought directly in a United States Court of  
3           Appeal under subsection (c), or in the case of an ap-  
4           peal of an action brought in a district court under  
5           subsection (b), such Court shall complete all action  
6           on the petition, including the issuance of a judg-  
7           ment, prior to the end of the 60-day period begin-  
8           ning on the date on which such petition is filed with  
9           the Court, unless all parties to such proceeding  
10          agree to an extension of such period.

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

16          **“SEC. 2915. ONGOING REVIEW.**

17          “Not later than 5 years after the date on which the  
18          Model Small Group Rating Rules are issued under this  
19          part, and every 5 years thereafter, the Secretary, in con-  
20          sultation with the National Association of Insurance Com-  
21          missioners, shall prepare and submit to the appropriate  
22          committees of Congress a report that assesses the effect  
23          of the Model Small Group Rating Rules on access, cost,  
24          and market functioning in the small group market. Such  
25          report may, if the Secretary, in consultation with the Na-

1 tional Association of Insurance Commissioners, deter-  
 2 mines such is appropriate for improving access, costs, and  
 3 market functioning, contain legislative proposals for rec-  
 4 ommended modification to such Model Small Group Rat-  
 5 ing Rules.

6 **“PART II—AFFORDABLE PLANS**

7 **“SEC. 2921. DEFINITIONS.**

8 “In this part:

9 “(1) **ADOPTING STATE.**—The term ‘adopting  
 10 State’ means a State that has enacted a law pro-  
 11 viding that small group, individual, and large group  
 12 health insurers in such State may offer and sell  
 13 products in accordance with the List of Required  
 14 Benefits and the Terms of Application as provided  
 15 for in section 2922(b).

16 “(2) **ELIGIBLE INSURER.**—The term ‘eligible  
 17 insurer’ means a health insurance issuer that is li-  
 18 censed in a nonadopting State and that—

19 “(A) notifies the Secretary, not later than  
 20 30 days prior to the offering of coverage de-  
 21 scribed in this subparagraph, that the issuer in-  
 22 tends to offer health insurance coverage con-  
 23 sistent with the List of Required Benefits and  
 24 Terms of Application in a nonadopting State;

1           “(B) notifies the insurance department of  
2 a nonadopting State (or other applicable State  
3 agency), not later than 30 days prior to the of-  
4 fering of coverage described in this subpara-  
5 graph, that the issuer intends to offer health in-  
6 surance coverage in that State consistent with  
7 the List of Required Benefits and Terms of Ap-  
8 plication, and provides with such notice a copy  
9 of any insurance policy that it intends to offer  
10 in the State, its most recent annual and quar-  
11 terly financial reports, and any other informa-  
12 tion required to be filed with the insurance de-  
13 partment of the State (or other State agency)  
14 by the Secretary in regulations; and

15           “(C) includes in the terms of the health in-  
16 surance coverage offered in nonadopting States  
17 (including in the terms of any individual certifi-  
18 cates that may be offered to individuals in con-  
19 nection with such group health coverage) and  
20 filed with the State pursuant to subparagraph  
21 (B), a description in the insurer’s contract of  
22 the List of Required Benefits and a description  
23 of the Terms of Application, including a de-  
24 scription of the benefits to be provided, and

1           that adherence to such standards is included as  
2           a term of such contract.

3           “(3) HEALTH INSURANCE COVERAGE.—The  
4           term ‘health insurance coverage’ means any coverage  
5           issued in the small group, individual, or large group  
6           health insurance markets, including with respect to  
7           small business health plans, except that such term  
8           shall not include excepted benefits (as defined in sec-  
9           tion 2791(c)).

10           “(4) LIST OF REQUIRED BENEFITS.—The term  
11           ‘List of Required Benefits’ means the List issued  
12           under section 2922(a).

13           “(5) NONADOPTING STATE.—The term ‘non-  
14           adopting State’ means a State that is not an adopt-  
15           ing State.

16           “(6) STATE LAW.—The term ‘State law’ means  
17           all laws, decisions, rules, regulations, or other State  
18           actions (including actions by a State agency) having  
19           the effect of law, of any State.

20           “(7) STATE PROVIDER FREEDOM OF CHOICE  
21           LAW.—The term ‘State Provider Freedom of Choice  
22           Law’ means a State law requiring that a health in-  
23           surance issuer, with respect to health insurance cov-  
24           erage, not discriminate with respect to participation,  
25           reimbursement, or indemnification as to any pro-

1 vider who is acting within the scope of the provider’s  
2 license or certification under applicable State law.

3 “(8) TERMS OF APPLICATION.—The term  
4 ‘Terms of Application’ means terms provided under  
5 section 2922(a).

6 **“SEC. 2922. OFFERING AFFORDABLE PLANS.**

7 “(a) LIST OF REQUIRED BENEFITS.—Not later than  
8 3 months after the date of enactment of this title, the Sec-  
9 retary, in consultation with the National Association of In-  
10 surance Commissioners, shall issue by interim final rule  
11 a list (to be known as the ‘List of Required Benefits’) of  
12 covered benefits, services, or categories of providers that  
13 are required to be provided by health insurance issuers,  
14 in each of the small group, individual, and large group  
15 markets, in at least 26 States as a result of the application  
16 of State covered benefit, service, and category of provider  
17 mandate laws. With respect to plans sold to or through  
18 small business health plans, the List of Required Benefits  
19 applicable to the small group market shall apply.

20 “(b) TERMS OF APPLICATION.—

21 “(1) STATE WITH MANDATES.—With respect to  
22 a State that has a covered benefit, service, or cat-  
23 egory of provider mandate in effect that is covered  
24 under the List of Required Benefits under sub-  
25 section (a), such State mandate shall, subject to

1 paragraph (3) (concerning uniform application),  
2 apply to a coverage plan or plan in, as applicable,  
3 the small group, individual, or large group market or  
4 through a small business health plan in such State.

5 “(2) STATES WITHOUT MANDATES.—With re-  
6 spect to a State that does not have a covered ben-  
7 efit, service, or category of provider mandate in ef-  
8 fect that is covered under the List of Required Ben-  
9 efits under subsection (a), such mandate shall not  
10 apply, as applicable, to a coverage plan or plan in  
11 the small group, individual, or large group market or  
12 through a small business health plan in such State.

13 “(3) UNIFORM APPLICATION OF LAWS.—

14 “(A) IN GENERAL.—With respect to a  
15 State described in paragraph (1), in applying a  
16 covered benefit, service, or category of provider  
17 mandate that is on the List of Required Bene-  
18 fits under subsection (a) the State shall permit  
19 a coverage plan or plan offered in the small  
20 group, individual, or large group market or  
21 through a small business health plan in such  
22 State to apply such benefit, service, or category  
23 of provider coverage in a manner consistent  
24 with the manner in which such coverage is ap-  
25 plied under one of the three most heavily sub-

1           scribed national health plans offered under the  
2           Federal Employee Health Benefits Program  
3           under chapter 89 of title 5, United States Code  
4           (as determined by the Secretary in consultation  
5           with the Director of the Office of Personnel  
6           Management), and consistent with the Publica-  
7           tion of Benefit Applications under subsection  
8           (c). In the event a covered benefit, service, or  
9           category of provider appearing in the List of  
10          Required Benefits is not offered in one of the  
11          three most heavily subscribed national health  
12          plans offered under the Federal Employees  
13          Health Benefits Program, such covered benefit,  
14          service, or category of provider requirement  
15          shall be applied in a manner consistent with the  
16          manner in which such coverage is offered in the  
17          remaining most heavily subscribed plan of the  
18          remaining Federal Employees Health Benefits  
19          Program plans, as determined by the Secretary,  
20          in consultation with the Director of the Office  
21          of Personnel Management.

22                 “(B) EXCEPTION REGARDING STATE PRO-  
23                 VIDER FREEDOM OF CHOICE LAWS.—Notwith-  
24                 standing subparagraph (A), in the event a cat-  
25                 egory of provider mandate is included in the

1 List of Covered Benefits, any State Provider  
2 Freedom of Choice Law (as defined in section  
3 2921(7)) that is in effect in any State in which  
4 such category of provider mandate is in effect  
5 shall not be preempted, with respect to that cat-  
6 egory of provider, by this part.

7 “(c) PUBLICATION OF BENEFIT APPLICATIONS.—  
8 Not later than 3 months after the date of enactment of  
9 this title, and on the first day of every calendar year there-  
10 after, the Secretary, in consultation with the Director of  
11 the Office of Personnel Management, shall publish in the  
12 Federal Register a description of such covered benefits,  
13 services, and categories of providers covered in that cal-  
14 endar year by each of the three most heavily subscribed  
15 nationally available Federal Employee Health Benefits  
16 Plan options which are also included on the List of Re-  
17 quired Benefits.

18 “(d) EFFECTIVE DATES.—

19 “(1) SMALL BUSINESS HEALTH PLANS.—With  
20 respect to health insurance provided to participating  
21 employers of small business health plans, the re-  
22 quirements of this part (concerning lower cost plans)  
23 shall apply beginning on the date that is 12 months  
24 after the date of enactment of this title.

1           “(2) NON-ASSOCIATION COVERAGE.—With re-  
2           spect to health insurance provided to groups or indi-  
3           viduals other than participating employers of small  
4           business health plans, the requirements of this part  
5           shall apply beginning on the date that is 15 months  
6           after the date of enactment of this title.

7           “(e) UPDATING OF LIST OF REQUIRED BENEFITS.—  
8           Not later than 2 years after the date on which the list  
9           of required benefits is issued under subsection (a), and  
10          every 2 years thereafter, the Secretary, in consultation  
11          with the National Association of Insurance Commis-  
12          sioners, shall update the list based on changes in the laws  
13          and regulations of the States. The Secretary shall issue  
14          the updated list by regulation, and such updated list shall  
15          be effective upon the first plan year following the issuance  
16          of such regulation.

17          **“SEC. 2923. APPLICATION AND PREEMPTION.**

18          “(a) SUPERCEDING OF STATE LAW.—

19                 “(1) IN GENERAL.—This part shall supersede  
20                 any and all State laws insofar as such laws relate to  
21                 mandates relating to covered benefits, services, or  
22                 categories of provider in the health insurance market  
23                 as applied to an eligible insurer, or health insurance  
24                 coverage issued by an eligible insurer, including with

1 respect to coverage issued to a small business health  
2 plan, in a nonadopting State.

3 “(2) NONADOPTING STATES.—This part shall  
4 supersede any and all State laws of a nonadopting  
5 State (whether enacted prior to or after the date of  
6 enactment of this title) insofar as such laws—

7 “(A) prohibit an eligible insurer from of-  
8 fering, marketing, or implementing health in-  
9 surance coverage consistent with the Benefit  
10 Choice Standards, as provided for in section  
11 2922(a); or

12 “(B) have the effect of retaliating against  
13 or otherwise punishing in any respect an eligible  
14 insurer for offering, marketing, or imple-  
15 menting health insurance coverage consistent  
16 with the Benefit Choice Standards.

17 “(b) SAVINGS CLAUSE AND CONSTRUCTION.—

18 “(1) NONAPPLICATION TO ADOPTING STATES.—  
19 Subsection (a) shall not apply with respect to adopt-  
20 ing States.

21 “(2) NONAPPLICATION TO CERTAIN INSUR-  
22 ERS.—Subsection (a) shall not apply with respect to  
23 insurers that do not qualify as eligible insurers who  
24 offer health insurance coverage in a nonadopting  
25 State.

1           “(3) NONAPPLICATION WHERE OBTAINING RE-  
2           LIEF UNDER STATE LAW.—Subsection (a)(1) shall  
3           not supercede any State law of a nonadopting State  
4           to the extent necessary to permit individuals or the  
5           insurance department of the State (or other State  
6           agency) to obtain relief under State law to require  
7           an eligible insurer to comply with the Benefit Choice  
8           Standards.

9           “(4) NO EFFECT ON PREEMPTION.—In no case  
10          shall this part be construed to limit or affect in any  
11          manner the preemptive scope of sections 502 and  
12          514 of the Employee Retirement Income Security  
13          Act of 1974. In no case shall this part be construed  
14          to create any cause of action under Federal or State  
15          law or enlarge or affect any remedy available under  
16          the Employee Retirement Income Security Act of  
17          1974.

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

1 **“SEC. 2924. CIVIL ACTIONS AND JURISDICTION.**

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

5       “(b) ACTIONS.—An eligible insurer may bring an ac-  
6 tion in the district courts of the United States for injunc-  
7 tive or other equitable relief against any officials or agents  
8 of a nonadopting State in connection with any conduct or  
9 action, or proposed conduct or action, by such officials or  
10 agents which violates, or which would if undertaken vio-  
11 late, section 2923.

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

18       “(d) EXPEDITED REVIEW.—

19               “(1) DISTRICT COURT.—In the case of an ac-  
20 tion brought in a district court of the United States  
21 under subsection (b), such court shall complete such  
22 action, including the issuance of a judgment, prior  
23 to the end of the 120-day period beginning on the  
24 date on which such action is filed, unless all parties  
25 to such proceeding agree to an extension of such pe-  
26 riod.

1           “(2) COURT OF APPEALS.—In the case of an  
2           action brought directly in a United States Court of  
3           Appeal under subsection (c), or in the case of an ap-  
4           peal of an action brought in a district court under  
5           subsection (b), such Court shall complete all action  
6           on the petition, including the issuance of a judg-  
7           ment, prior to the end of the 60-day period begin-  
8           ning on the date on which such petition is filed with  
9           the Court, unless all parties to such proceeding  
10          agree to an extension of such period.

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

16          **“SEC. 2925. RULES OF CONSTRUCTION.**

17          “(a) IN GENERAL.—Notwithstanding any other pro-  
18          vision of Federal or State law, a health insurance issuer  
19          in an adopting State or an eligible insurer in a non-adopt-  
20          ing State may amend its existing policies to be consistent  
21          with the terms of this subtitle (concerning rating and ben-  
22          efits).

23          “(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this  
24          subtitle shall be construed to create any mandates for cov-  
25          erage of benefits for HSA-qualified health plans that

1 would require reimbursements in violation of section  
2 223(c)(2) of the Internal Revenue Code of 1986.”.

3 **TITLE III—HARMONIZATION OF**  
4 **HEALTH INSURANCE STAND-**  
5 **ARDS**

6 **SEC. 301. HEALTH INSURANCE STANDARDS HARMONI-**  
7 **ZATION.**

8 Title XXIX of the Public Health Service Act (as  
9 added by section 201) is amended by adding at the end  
10 the following:

11 **“Subtitle B—Standards**  
12 **Harmonization**

13 **“SEC. 2931. DEFINITIONS.**

14 “In this subtitle:

15 “(1) **ADOPTING STATE.**—The term ‘adopting  
16 State’ means a State that has enacted the har-  
17 monized standards adopted under this subtitle in  
18 their entirety and as the exclusive laws of the State  
19 that relate to the harmonized standards.

20 “(2) **ELIGIBLE INSURER.**—The term ‘eligible  
21 insurer’ means a health insurance issuer that is li-  
22 censed in a nonadopting State and that—

23 “(A) notifies the Secretary, not later than  
24 30 days prior to the offering of coverage de-  
25 scribed in this subparagraph, that the issuer in-

1 tends to offer health insurance coverage con-  
2 sistent with the harmonized standards in a non-  
3 adopting State;

4 “(B) notifies the insurance department of  
5 a nonadopting State (or other State agency),  
6 not later than 30 days prior to the offering of  
7 coverage described in this subparagraph, that  
8 the issuer intends to offer health insurance cov-  
9 erage in that State consistent with the har-  
10 monized standards published pursuant to sec-  
11 tion 2933(d), and provides with such notice a  
12 copy of any insurance policy that it intends to  
13 offer in the State, its most recent annual and  
14 quarterly financial reports, and any other infor-  
15 mation required to be filed with the insurance  
16 department of the State (or other State agency)  
17 by the Secretary in regulations; and

18 “(C) includes in the terms of the health in-  
19 surance coverage offered in nonadopting States  
20 (including in the terms of any individual certifi-  
21 cates that may be offered to individuals in con-  
22 nection with such health coverage) and filed  
23 with the State pursuant to subparagraph (B), a  
24 description of the harmonized standards pub-  
25 lished pursuant to section 2933(g)(2) and an

1           affirmation that such standards are a term of  
2           the contract.

3           “(3) HARMONIZED STANDARDS.—The term  
4           ‘harmonized standards’ means the standards cer-  
5           tified by the Secretary under section 2933(d).

6           “(4) HEALTH INSURANCE COVERAGE.—The  
7           term ‘health insurance coverage’ means any coverage  
8           issued in the health insurance market, except that  
9           such term shall not include excepted benefits (as de-  
10          fined in section 2791(c).

11          “(5) NONADOPTING STATE.—The term ‘non-  
12          adopting State’ means a State that fails to enact,  
13          within 18 months of the date on which the Secretary  
14          certifies the harmonized standards under this sub-  
15          title, the harmonized standards in their entirety and  
16          as the exclusive laws of the State that relate to the  
17          harmonized standards.

18          “(6) STATE LAW.—The term ‘State law’ means  
19          all laws, decisions, rules, regulations, or other State  
20          actions (including actions by a State agency) having  
21          the effect of law, of any State.

22   **“SEC. 2932. HARMONIZED STANDARDS.**

23          “(a) BOARD.—

24                  “(1) ESTABLISHMENT.—Not later than 3  
25                  months after the date of enactment of this title, the

1 Secretary, in consultation with the NAIC, shall es-  
2 tablish the Health Insurance Consensus Standards  
3 Board (referred to in this subtitle as the ‘Board’) to  
4 develop recommendations that harmonize incon-  
5 sistent State health insurance laws in accordance  
6 with the procedures described in subsection (b).

7 “(2) COMPOSITION.—

8 “(A) IN GENERAL.—The Board shall be  
9 composed of the following voting members to be  
10 appointed by the Secretary after considering the  
11 recommendations of professional organizations  
12 representing the entities and constituencies de-  
13 scribed in this paragraph:

14 “(i) Four State insurance commis-  
15 sioners as recommended by the National  
16 Association of Insurance Commissioners, of  
17 which 2 shall be Democrats and 2 shall be  
18 Republicans, and of which one shall be des-  
19 ignated as the chairperson and one shall be  
20 designated as the vice chairperson.

21 “(ii) Four representatives of State  
22 government, two of which shall be gov-  
23 ernors of States and two of which shall be  
24 State legislators, and two of which shall be

1 Democrats and two of which shall be Re-  
2 publicans.

3 “(iii) Four representatives of health  
4 insurers, of which one shall represent in-  
5 surers that offer coverage in the small  
6 group market, one shall represent insurers  
7 that offer coverage in the large group mar-  
8 ket, one shall represent insurers that offer  
9 coverage in the individual market, and one  
10 shall represent carriers operating in a re-  
11 gional market.

12 “(iv) Two representatives of insurance  
13 agents and brokers.

14 “(v) Two independent representatives  
15 of the American Academy of Actuaries who  
16 have familiarity with the actuarial methods  
17 applicable to health insurance.

18 “(B) EX OFFICIO MEMBER.—A representa-  
19 tive of the Secretary shall serve as an ex officio  
20 member of the Board.

21 “(3) ADVISORY PANEL.—The Secretary shall  
22 establish an advisory panel to provide advice to the  
23 Board, and shall appoint its members after consid-  
24 ering the recommendations of professional organiza-

1 tions representing the entities and constituencies  
2 identified in this paragraph:

3 “(A) Two representatives of small business  
4 health plans.

5 “(B) Two representatives of employers, of  
6 which one shall represent small employers and  
7 one shall represent large employers.

8 “(C) Two representatives of consumer or-  
9 ganizations.

10 “(D) Two representatives of health care  
11 providers.

12 “(4) QUALIFICATIONS.—The membership of the  
13 Board shall include individuals with national rec-  
14 ognition for their expertise in health finance and ec-  
15 onomics, actuarial science, health plans, providers of  
16 health services, and other related fields, who provide  
17 a mix of different professionals, broad geographic  
18 representation, and a balance between urban and  
19 rural representatives.

20 “(5) ETHICAL DISCLOSURE.—The Secretary  
21 shall establish a system for public disclosure by  
22 members of the Board of financial and other poten-  
23 tial conflicts of interest relating to such members.  
24 Members of the Board shall be treated as employees  
25 of Congress for purposes of applying title I of the

1 Ethics in Government Act of 1978 (Public Law 95–  
2 521).

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

7 “(A) employ and fix the compensation of  
8 an Executive Director (subject to the approval  
9 of the Comptroller General) and such other per-  
10 sonnel as may be necessary to carry out its du-  
11 ties (without regard to the provisions of title 5,  
12 United States Code, governing appointments in  
13 the competitive service);

14 “(B) seek such assistance and support as  
15 may be required in the performance of its du-  
16 ties from appropriate Federal departments and  
17 agencies;

18 “(C) enter into contracts or make other ar-  
19 rangements, as may be necessary for the con-  
20 duct of the work of the Board (without regard  
21 to section 3709 of the Revised Statutes (41  
22 U.S.C. 5));

23 “(D) make advance, progress, and other  
24 payments which relate to the work of the  
25 Board;

1           “(E) provide transportation and subsist-  
2           ence for persons serving without compensation;  
3           and

4           “(F) prescribe such rules as it deems nec-  
5           essary with respect to the internal organization  
6           and operation of the Board.

7           “(7) TERMS.—The members of the Board shall  
8           serve for the duration of the Board. Vacancies in the  
9           Board shall be filled as needed in a manner con-  
10          sistent with the composition described in paragraph  
11          (2).

12          “(b) DEVELOPMENT OF HARMONIZED STAND-  
13          ARDS.—

14               “(1) IN GENERAL.—In accordance with the  
15               process described in subsection (c), the Board shall  
16               identify and recommend nationally harmonized  
17               standards for each of the following process cat-  
18               egories:

19                       “(A) FORM FILING AND RATE FILING.—  
20                       Form and rate filing standards shall be estab-  
21                       lished which promote speed to market and in-  
22                       clude the following defined areas for States that  
23                       require such filings:

1           “(i) Procedures for form and rate fil-  
2           ing pursuant to a streamlined administra-  
3           tive filing process.

4           “(ii) Timeframes for filings to be re-  
5           viewed by a State if review is required be-  
6           fore they are deemed approved.

7           “(iii) Timeframes for an eligible in-  
8           surer to respond to State requests fol-  
9           lowing its review.

10          “(iv) A process for an eligible insurer  
11          to self-certify.

12          “(v) State development of form and  
13          rate filing templates that include only non-  
14          preempted State law and Federal law re-  
15          quirements for eligible insurers with timely  
16          updates.

17          “(vi) Procedures for the resubmission  
18          of forms and rates.

19          “(vii) Disapproval rationale of a form  
20          or rate filing based on material omissions  
21          or violations of non-preempted State law or  
22          Federal law with violations cited and ex-  
23          plained.

24          “(viii) For States that may require a  
25          hearing, a rationale for hearings based on

1 violations of non-preempted State law or  
2 insurer requests.

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

6 “(i) Mandatory participation in na-  
7 tional databases.

8 “(ii) The confidentiality of examina-  
9 tion materials.

10 “(iii) The identification of the State  
11 agency with primary responsibility for ex-  
12 aminations.

13 “(iv) Consultation and verification of  
14 complaint data with the eligible insurer  
15 prior to State actions.

16 “(v) Consistency of reporting require-  
17 ments with the recordkeeping and adminis-  
18 trative practices of the eligible insurer.

19 “(vi) Examinations that seek to cor-  
20 rect material errors and harmful business  
21 practices rather than infrequent errors.

22 “(vii) Transparency and publishing of  
23 the State’s examination standards.

24 “(viii) Coordination of market conduct  
25 analysis.

1                   “(ix) Coordination and nonduplication  
2                   between State examinations of the same el-  
3                   igible insurer.

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

6                   “(xi) Requirements on examiners  
7                   prior to beginning examinations such as  
8                   budget planning and work plans.

9                   “(xii) Consideration of methods to  
10                  limit examiners’ fees such as caps, com-  
11                  petitive bidding, or other alternatives.

12                  “(xiii) Reasonable fines and penalties  
13                  for material errors and harmful business  
14                  practices.

15                  “(C) PROMPT PAYMENT OF CLAIMS.—The  
16                  Board shall establish prompt payment stand-  
17                  ards for eligible insurers based on standards  
18                  similar to those applicable to the Social Secu-  
19                  rity Act as set forth in section 1842(c)(2) of  
20                  such Act (42 U.S.C. 1395u(c)(2)). Such prompt  
21                  payment standards shall be consistent with the  
22                  timing and notice requirements of the claims  
23                  procedure rules to be specified under subpara-  
24                  graph (D), and shall include appropriate excep-

1           tions such as for fraud, nonpayment of pre-  
2           miums, or late submission of claims.

3           “(D) INTERNAL REVIEW.—The Board  
4           shall establish standards for claims procedures  
5           for eligible insurers that are consistent with the  
6           requirements relating to initial claims for bene-  
7           fits and appeals of claims for benefits under the  
8           Employee Retirement Income Security Act of  
9           1974 as set forth in section 503 of such Act  
10          (29 U.S.C. 1133) and the regulations there-  
11          under.

12          “(2) RECOMMENDATIONS.—The Board shall  
13          recommend harmonized standards for each element  
14          of the categories described in subparagraph (A)  
15          through (D) of paragraph (1) within each such mar-  
16          ket. Notwithstanding the previous sentence, the  
17          Board shall not recommend any harmonized stand-  
18          ards that disrupt, expand, or duplicate the benefit,  
19          service, or provider mandate standards provided in  
20          the Benefit Choice Standards pursuant to section  
21          2922(a).

22          “(c) PROCESS FOR IDENTIFYING HARMONIZED  
23          STANDARDS.—

24          “(1) IN GENERAL.—The Board shall develop  
25          recommendations to harmonize inconsistent State in-

1 insurance laws with respect to each of the process cat-  
2 egories described in subparagraphs (A) through (D)  
3 of subsection (b)(1).

4 “(2) REQUIREMENTS.—In adopting standards  
5 under this section, the Board shall consider the fol-  
6 lowing:

7 “(A) Any model acts or regulations of the  
8 National Association of Insurance Commis-  
9 sioners in each of the process categories de-  
10 scribed in subparagraphs (A) through (D) of  
11 subsection (b)(1).

12 “(B) Substantially similar standards fol-  
13 lowed by a plurality of States, as reflected in  
14 existing State laws, relating to the specific proc-  
15 ess categories described in subparagraphs (A)  
16 through (D) of subsection (b)(1).

17 “(C) Any Federal law requirement related  
18 to specific process categories described in sub-  
19 paragraphs (A) through (D) of subsection  
20 (b)(1).

21 “(D) In the case of the adoption of any  
22 standard that differs substantially from those  
23 referred to in subparagraphs (A), (B), or (C),  
24 the Board shall provide evidence to the Sec-  
25 retary that such standard is necessary to pro-

1 tect health insurance consumers or promote  
2 speed to market or administrative efficiency.

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

5 “(d) RECOMMENDATIONS AND CERTIFICATION BY  
6 SECRETARY.—

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

13 “(2) CERTIFICATION.—

14 “(A) IN GENERAL.—Not later than 120  
15 days after receipt of the Board’s recommenda-  
16 tions under paragraph (1), the Secretary shall  
17 certify the recommended harmonized standards  
18 as provided for in subparagraph (B), and issue  
19 such standards in the form of an interim final  
20 regulation.

21 “(B) CERTIFICATION PROCESS.—The Sec-  
22 retary shall establish a process for certifying  
23 the recommended harmonized standard, by cat-  
24 egory, as recommended by the Board under this  
25 section. Such process shall—

1           “(i) ensure that the certified stand-  
2           ards for a particular process area achieve  
3           regulatory harmonization with respect to  
4           health plans on a national basis;

5           “(ii) ensure that the approved stand-  
6           ards are the minimum necessary, with re-  
7           gard to substance and quantity of require-  
8           ments, to protect health insurance con-  
9           sumers and maintain a competitive regu-  
10          latory environment; and

11          “(iii) ensure that the approved stand-  
12          ards will not limit the range of group  
13          health plan designs and insurance prod-  
14          ucts, such as catastrophic coverage only  
15          plans, health savings accounts, and health  
16          maintenance organizations, that might oth-  
17          erwise be available to consumers.

18          “(3) APPLICATION AND EFFECTIVE DATE.—  
19          The standards certified by the Secretary under para-  
20          graph (2) shall apply and become effective on the  
21          date that is 18 months after the date on which the  
22          Secretary certifies the harmonized standards.

23          “(e) TERMINATION.—The Board shall terminate and  
24          be dissolved after making the recommendations to the Sec-  
25          retary pursuant to subsection (d)(1).

1       “(f) ONGOING REVIEW.—Not earlier than 3 years  
2 after the termination of the Board under subsection (e),  
3 and not earlier than every 3 years thereafter, the Sec-  
4 retary, in consultation with the National Association of In-  
5 surance Commissioners and the entities and constituencies  
6 represented on the Board and the Advisory Panel, shall  
7 prepare and submit to the appropriate committees of Con-  
8 gress a report that assesses the effect of the harmonized  
9 standards applied under this section on access, cost, and  
10 health insurance market functioning. The Secretary may,  
11 based on such report and applying the process established  
12 for certification under subsection (d)(2)(B), in consulta-  
13 tion with the National Association of Insurance Commis-  
14 sioners and the entities and constituencies represented on  
15 the Board and the Advisory Panel, update the harmonized  
16 standards through notice and comment rulemaking.

17       “(g) PUBLICATION.—

18               “(1) LISTING.—The Secretary shall maintain  
19 an up to date listing of all harmonized standards  
20 certified under this section on the Internet website  
21 of the Department of Health and Human Services.

22               “(2) SAMPLE CONTRACT LANGUAGE.—The Sec-  
23 retary shall publish on the Internet website of the  
24 Department of Health and Human Services sample  
25 contract language that incorporates the harmonized

1 standards certified under this section, which may be  
2 used by insurers seeking to qualify as an eligible in-  
3 surer. The types of harmonized standards that shall  
4 be included in sample contract language are the  
5 standards that are relevant to the contractual bar-  
6 gain between the insurer and insured.

7 “(h) STATE ADOPTION AND ENFORCEMENT.—Not  
8 later than 18 months after the certification by the Sec-  
9 retary of harmonized standards under this section, the  
10 States may adopt such harmonized standards (and become  
11 an adopting State) and, in which case, shall enforce the  
12 harmonized standards pursuant to State law.

13 **“SEC. 2933. APPLICATION AND PREEMPTION.**

14 “(a) SUPERCEDING OF STATE LAW.—

15 “(1) IN GENERAL.—The harmonized standards  
16 certified under this subtitle and applied as provided  
17 for in section 2933(d)(3), shall supersede any and  
18 all State laws of a non-adopting State insofar as  
19 such State laws relate to the areas of harmonized  
20 standards as applied to an eligible insurer, or health  
21 insurance coverage issued by a eligible insurer, in-  
22 cluding with respect to coverage issued to a small  
23 business health plan, in a nonadopting State.

24 “(2) NONADOPTING STATES.—This subtitle  
25 shall supersede any and all State laws of a non-

1 adopting State (whether enacted prior to or after the  
2 date of enactment of this title) insofar as they  
3 may—

4 “(A) prohibit an eligible insurer from of-  
5 fering, marketing, or implementing health in-  
6 surance coverage consistent with the har-  
7 monized standards; or

8 “(B) have the effect of retaliating against  
9 or otherwise punishing in any respect an eligible  
10 insurer for offering, marketing, or imple-  
11 menting health insurance coverage consistent  
12 with the harmonized standards under this sub-  
13 title.

14 “(b) SAVINGS CLAUSE AND CONSTRUCTION.—

15 “(1) NONAPPLICATION TO ADOPTING STATES.—  
16 Subsection (a) shall not apply with respect to adopt-  
17 ing States.

18 “(2) NONAPPLICATION TO CERTAIN INSUR-  
19 ERS.—Subsection (a) shall not apply with respect to  
20 insurers that do not qualify as eligible insurers who  
21 offer health insurance coverage in a nonadopting  
22 State.

23 “(3) NONAPPLICATION WHERE OBTAINING RE-  
24 LIEF UNDER STATE LAW.—Subsection (a)(1) shall  
25 not supercede any State law of a nonadopting State

1 to the extent necessary to permit individuals or the  
2 insurance department of the State (or other State  
3 agency) to obtain relief under State law to require  
4 an eligible insurer to comply with the harmonized  
5 standards under this subtitle.

6 “(4) NO EFFECT ON PREEMPTION.—In no case  
7 shall this subtitle be construed to limit or affect in  
8 any manner the preemptive scope of sections 502  
9 and 514 of the Employee Retirement Income Secu-  
10 rity Act of 1974. In no case shall this subtitle be  
11 construed to create any cause of action under Fed-  
12 eral or State law or enlarge or affect any remedy  
13 available under the Employee Retirement Income  
14 Security Act of 1974.

15 “(c) EFFECTIVE DATE.—This section shall apply be-  
16 ginning on the date that is 18 months after the date on  
17 harmonized standards are certified by the Secretary under  
18 this subtitle.

19 **“SEC. 2934. CIVIL ACTIONS AND JURISDICTION.**

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

23 “(b) ACTIONS.—An eligible insurer may bring an ac-  
24 tion in the district courts of the United States for injunc-  
25 tive or other equitable relief against any officials or agents

1 of a nonadopting State in connection with any conduct or  
2 action, or proposed conduct or action, by such officials or  
3 agents which violates, or which would if undertaken vio-  
4 late, section 2933.

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

11 “(d) EXPEDITED REVIEW.—

12 “(1) DISTRICT COURT.—In the case of an ac-  
13 tion brought in a district court of the United States  
14 under subsection (b), such court shall complete such  
15 action, including the issuance of a judgment, prior  
16 to the end of the 120-day period beginning on the  
17 date on which such action is filed, unless all parties  
18 to such proceeding agree to an extension of such pe-  
19 riod.

20 “(2) COURT OF APPEALS.—In the case of an  
21 action brought directly in a United States Court of  
22 Appeal under subsection (c), or in the case of an ap-  
23 peal of an action brought in a district court under  
24 subsection (b), such Court shall complete all action  
25 on the petition, including the issuance of a judg-

1       ment, prior to the end of the 60-day period begin-  
2       ning on the date on which such petition is filed with  
3       the Court, unless all parties to such proceeding  
4       agree to an extension of such period.

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

10    **“SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE**  
11                                   **OF CONSTRUCTION.**

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

15       “(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this  
16       subtitle shall be construed to create any mandates for cov-  
17       erage of any benefits below the deductible levels set for  
18       any health savings account-qualified health plan pursuant  
19       to section 223 of the Internal Revenue Code of 1986.”.

○